IMPROVING HEALTH SECTOR COORDINATION
IN JONGLEI STATE, SOUTHERN SUDAN

From Project Coordination to Health Sector Governance

Phase-1 Report
IMA World Health - SuddHealth Project
Technical Support to Health Sector Steering Committees

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MAP OF SOUTHERN SUDAN

1 http://www.goss-brussels.com/goss.php/map.goss
EXECUTIVE SUMMARY

ETC Crystal is a consortium member and partners with IMA World Health in the implementation of the SuddHealth project in Jonglei State in Southern Sudan. The project is funded by the Multi-Donor Trust Fund (MDTF) aimed at strengthening the health system and the provision of PHC. In view of the first objective (strengthen the capacity of the SMOH and the County Health Departments) ETC Crystal has been requested to assist with the establishment of Health Sector Steering Committees (HSSCs) at State levels.

This report is the reflection of a first exploratory mission, conducted in the period 23rd August to 3rd of September 2010. The aim of this mission was to investigate the current health sector context and to get an informed opinion on the appropriateness, best options and alternatives for the establishment of the said HSSCs.

Based on the mission findings, this report recommends approaching the coordination of the health sector from a broader perspective than originally aimed for in the TOR. The report recommends taking a more comprehensive approach towards governance and coordination, instead of focussing only on the establishment of coordination meetings as seems to be implied in the original design of the SuddHealth project. This more comprehensive approach will be more appropriate to achieve strengthening the health system in the longer run, a core objective of the programme. The report provides justification for this shift in focus and gives specific recommendations with respect to establishment and management of regular Health Sector Coordination Meetings at Jonglei State. This report forms the basis for developing the strategic direction and content of the 2nd and 3rd phase of this assignment which are scheduled in October and November 2010, respectively. These subsequent phases aim to prepare for and facilitate the establishment of health coordination meetings in Jonglei State.

The observations during the visit to South Sudan and the reports indicate serious problems in management capacity at Jonglei State and even more at its respective County levels. Many of the staff are not qualified for the tasks at hand. Many of the health facilities are not functional; others are running but with dilapidated structures. The standards of health service delivery are in general very low. Implementation of the MDTF-Health programme in the SuddHealth Project has only formally started in June 2010. Release of funds has been seriously delayed. The need for support from NGOs is recognised in policy documents and by all parties involved. At GoSS level the health coordination between all relevant parties has been fairly well organised, although some overlap between the NGO Health Sector Forum and the Health Assembly is being discussed. In Jonglei State there is still lack of sufficient and effective coordination. Health Coordination Meetings are being held, but these are held irregular and usually with low attendance. The meetings are still dominated by emergency response issues instead of being aimed at governance and comprehensive health planning.

With respect to improving the general coordination in the health sector, the report suggests that a wide variety of coordination mechanisms and –elements should be considered such as coordination meetings, supportive supervision, HMIS, dissemination of information etc. It is argued that these various elements are mutually reinforcing health sector coordination. It is recommended that the most suitable combination of coordination elements will be initiated and supported in line with IMA’s capabilities and matching local needs and priorities.

Considering support to the establishment of sector coordination meetings, this report recommends that parallel structures should be avoided and that new meetings could be best based on existing structures. However, the coordination meetings should be less frequent, more purposeful and better prepared, managed and followed up. The outlook of coordination meetings should change from an emergency response orientation to a more developmental one, that is, contributing to strengthening essential elements of the health system such as planning, M&E, logistics, drug supply, procurement, oversight, HRH training, etc. Thus, coordination meetings should be supportive to assist health managers to execute their responsibilities and to support partners in executing their programs more effectively. It is argued that this approach will engage partners rather than discourage them. Next to establishing quarterly health coordination meetings, the report suggests the importance of establishing monthly supportive supervision by Jonglei State Ministry of Health to the County Health Departments as this provides the elementary information to structure purposeful health sector coordination meetings.

* * *
ACRONYMS AND ABBREVIATIONS

AIDS Acquired Immune Deficiency Syndrome
BPH(N)S Basic Package of Health (and Nutrition) Services
CBO Community Based Organisation
CHAS Christian Health Association of Sudan
CHD County Health Department
CPA Comprehensive Peace Agreement
FBO Faith-Based Organisations
GOSS Government of South Sudan
GOSSHA Government of South Sudan Health Assembly
HIV Human Immunodeficiency virus
HMIS Health Management Information System
HSCM Health Sector Coordination Meeting
HSSC Health Sector Steering Committee
IMA Interchurch Medical Assistance
INGO International Non-Governmental Organisation
LA Lead Agency
M&E Monitoring & Evaluation
MDTF Multi-Donor Trust Fund
MOH Ministry of Health
MOU Memorandum of Understanding
NGO Non-Governmental Organisation
NPA Norwegian People's Aid
PHC Primary Health Care
PHCC Primary Health Care Centre
PHCU Primary Health Care Unit
SMC Sudan Medical Care
SMOH State Ministry of Health
SPMT State Project Management Team
SSRRC Southern Sudan Relief & Rehabilitation Committee
TICH Tropical Institute for Community Health and development
TOR Terms of Reference
UGPHSD Umbrella Grant Programme for Health Sector Development
UN United Nations
WHO World Health Organisation

* * *
1 BACKGROUND

1.1 Introduction

This chapter outlines a brief background for the consultant assignment and briefly summarizes important elements of the context. A first paragraph (1.2) elaborates on the Terms of Reference (TOR) for the assignment and the proposed work schedule. The following paragraph (1.3) presents an overview of the Multi-Donor Trust Fund (MDTF) programme and explains the specific role of Interchurch Medical Aid (IMA) World Health as lead Agent for Jonglei State. Paragraph (1.4) gives a brief historical sketch of Southern Sudan whereas the final paragraph (1.5) briefly describes some important features of Jonglei State.

1.2 Terms of Reference of the Assignment

With effect from July 2008, IMA World Health (IMA) and ETC Crystal have entered into a Memorandum of Understanding (appendix 1) as a basis for possible further cooperation within the Multi-donor Trust Fund (MDTF) contract for Jonglei State and also for Upper Nile State. At the end of June 2010, IMA requested ETC Crystal (appendix 2) to prepare a short concept paper for 1) the development of a framework and 2) guidelines for operating a State level Health Sector Steering Committee and 3) to conduct workshops to ensure HSSC links to County Health Councils. This assignment derived from the original plan of operations and the specific involvement of ETC to assist in reinforcing the capacity of the State Ministry of Health to supervise and support the work of County Health Departments (CHD) (“Component C” in appendix 2). The Concept Paper produced by ETC Crystal (appendix 3) was approved by IMA in July 2010 and a Sub-Grant Agreement (appendix 4) was signed between IMA and ETC Crystal mid August 2010.

The TOR for this assignment has a focus on technical support to the Health Sector Steering Committee (HSSC) in view of strengthening health systems in Southern Sudan. The assignment will be implemented in 3 distinct phases over time, each with a specific focus and related objectives as follows:

Phase 1: *Exploration and Assessment* (August-September 2010): Focus is on investigating the current health sector context through a situational analysis in order to come to an informed opinion on the appropriateness, best options or alternatives for the establishment of a HSSC. The outcome of phase 1 is to determine the content (‘roadmap’) for phase 2 and 3;

Phase 2: *Development of framework, guidelines and capacity building plan for a HSSC* (October 2010): Based on findings and approved recommendations of phase 1, specific tools, guidelines and protocols may need to be developed in preparation for phase 3;

Phase 3: *Capacity building and training* (November 2010): Factual training of stakeholders and facilitation of set-up of new institutions in Jonglei State.

This report is a reflection of phase 1. It is based on review of a wide range of documents such as MDTF documents, Government of South Sudan (GoSS) policy documents, review and assessment of the health sector, minutes of State level coordination meetings and national forums of Non-Governmental Organisations (NGOs) (appendix 5). Moreover, the report is based on interviews and in-depth discussions with a wide range of representative of key resource persons (see appendix 5 and appendix 7 for the itinerary) at the National, State and County levels such as IMA World Health, Government of South Sudan – Ministry of Health (MoH), State and County Government officials and health departments, World Health Organisation (WHO), Norwegian People’s Aid (NPA), International Non-Governmental organisations (INGOs), Christian Health Association of Sudan (CHAS) and local NGOs (see appendix 6). A field visit to Jonglei State (Bor) complemented the situational analysis.

1.3 The Multi Donor Trust Fund (MDTF)

The MDTF was established in January 2005 as part of the funding mechanisms to support reconstruction efforts in Sudan. The major focus of the MDTF has so far been on public works and infrastructure.

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2 Finding for Upper Nile State are reflected in a separate mission report.
3 Due to rainfall, it was not possible to visit health facilities outside Bor.
rehabilitation, strengthening core fiduciary systems and private sector development, rural water supply and sanitation, police and correctional services, and support to basic services in the health and education sectors. The fund is administered by the World Bank. The specific support for Health Sector Development within the MDTF was set-up through pledges of various donors and the Government of South Sudan (GOSS). 4 Part of the agreement was that the Government of Southern Sudan would commit two thirds of funding required for all MDTF projects. An oversight committee has been designed to strengthen dialogue and coordination of MDTF projects between GOSS, the UN, the World Bank and donors. Coordination between the UN and the World Bank faced some challenges at the beginning, mainly due to operational procedures, as the Bank procedures are not suitable for quick disbursements and delivery during the recovery phase. The delays experienced during the initial phase of the MDTF have proven somewhat detrimental to the transition process. 5 Because of the delay to get the MDTF operational a Basic Services Fund (BSF) was initiated to stop gap investments through NGOs and CBOs in Basic Services until the MDTF would be operational. During 2010 BSF funds provided to counties are much more substantial than the support provided through MDTF-Health funds. The MDTF was originally expected to enable the rapid expansion of basic services. Instead, however, it took a longer-term view of development planning. Consequently, building central government structures and capacity has been prioritised over the delivery of basic services. 6

One important component of the MDTF for the Health Sector Development aims to strengthen the health system by building up the administrative capacity of the MoH at National, State and County levels with main emphasis on improving stewardship, human resources for health, health sector financing, financial management and administration, PHC service provision and preventive medicine (see GoSS Health Policy 2007-2011). In order to support this component at the lower MoH levels, part of the MDTF funds are allocated to International NGOs contracted to work in a capacity as Lead Agent (LA) in a specific State working side-by-side with the State MOH (SMOH) with the aim to:

1) Strengthen the capacity of the SMOH and the County Health Departments and;
2) Sub-contract eligible NGOs and FBOs to provide PHC in State and Counties

Under the MDTF, IMA was awarded the contract as Lead Agent in two States: Jonglei and Upper Nile in 2008. The programme activities of IMA for both States are brought together in a 3-year project; the SuddHealth Project in which IMA partners in a consortium of three technical partners for project implementation (CHAS, Tropical Institute for Community Health and development (TICH) and ETC Crystal). Next to strengthening the health system at the State and County levels, the project emphasises the provision of priority interventions from the Basic Package of Health Services (BPHS), especially for preventive and promotive care, through Primary Health Care Centres (PHCCs) and Units (PHCU) and their respective community catchment areas. 7 NPA and HLSP were also selected as Lead Agents for resp. Central and Eastern Equatoria State. Later HLSP withdrew and an agreement for NPA to take on the Lead Agency role for Eastern Equatoria State is underway. Originally the plan was to have similar programmes in 10 states, but the contracts for 6 of the States have so far not been rewarded.

1.4 Southern Sudan

The territory of Southern Sudan borders Ethiopia to the east, Kenya, Uganda and the Democratic Republic of the Congo to the south and the Central African Republic to the west and Northern Sudan to the north. It is inhabited by approximately 12 million people that belong to over a hundred ethnic groups and speak about

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4 Under the funding arrangements of MDTF phase 2, additional combined contributions amounting to US$ 165m were pledged to cover additional expenditure such as the provision of the BPHS. However, of the committed US$ 80m by GoSS only US$ 15m were actually pledged for the 2009 budget resulting in shortfall of US$ 65m for 2010 and 2011. Matching funds from the MDTF donors are expected to decrease accordingly, with jeopardizing effects on the provision of essential health services.

5 http://www.unsudanig.org:Funding Mechanisms Final August 2008


7 The BPHS is developed as a medium term strategy to expand PHC. It comprises a selection of the most cost-effective elements of PHC such as: Immunization, Nutrition, Malaria, Maternal Health, Family Planning, etc.
400 languages. Southern Sudan consists of ten States each with Government administrative units and sector departments. The Central Government is located in Juba.

Since its independence in 1956, Southern Sudan has intermittently been at civil war with Northern Sudan. The last period of war, which lasted 25 years, came to a negotiated peace settlement in 2005 through the signing of the Comprehensive Peace Agreement (CPA). Several periods of war caused displacement of over 4 million people and caused the destruction of the whole infrastructure. The public health system was virtually inoperative. NGOs and FBOs were responsible for the majority of health service provision. Due to limited capacity of the NGOs, the insecurity and the vast area, only 25% of the population were reached. Most health facilities were destroyed and in need of major repairs and just 1 medical doctor was available for 500,000 people. Only three surgeons provided services in Southern Sudan in three hospitals (in Juba, Malakal and Wau).

The signing of the CPA marked the start of the rebuilding and development of Southern Sudan with financial and technical support from the Government of Southern Sudan, Western and Asian Governments and INGOs. With the establishment of the Ministry of Health and the decentralised tiers of MoH departments at State and County levels, the GoSS is on its way to establish a functional health system. However, with the conclusion of the CPA in the upcoming referendum (January 2011), the possible call for independence from Northern Sudan and on-going internal political conflicts, a stable future for Southern Sudan is far from secure.

### 1.5 Jonglei State

IMA World Health is appointed lead agent for MDTF programme in Jonglei State. The State was visited for this assignment. Jonglei State is located in the North-East of Southern Sudan where it borders Ethiopia. It has an estimated population of about 1,236,339 living in 13 counties and the municipality of Bor. The total land area is 317,138 square kilometres giving a population density of 3.9 people per square kilometre.

Although quality of infrastructure varies widely, there are an estimated 48 health facilities in operation. These facilities are run partly by Government, but mainly by an estimated 25 INGOs and 15 local NGOs (see appendix 8). A formal decentralized health system is slowly getting shape, guided by the overall direction of the MoH-GOSS policy 2006-2010. The State MoH in Jonglei State, is structured as the MoH GOSS level, headed by a Minister supported by a Director General (DG), supported by nine directorates. However, whereas the DG is appointed, still many directorates are vacant. County Health Departments are supposed to be manned by health management teams but in practice, many Counties lack health management teams in full or in part. IMA World Health is represented in Jonglei State with a State Project Management Team (SPMT). The SPMT is in charge of MDTF project implementation. Currently the SPMT is understaffed in relation to the original establishment and consists of 3 technical staff.

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8 Central Equatoria, Eastern Equatoria, Western Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Lakes, Warrap, Jonglei, Unity and Upper Nile, the capital of Central Equatoria.
9 The needs assessment of the UN-World Bank and Government of South Sudan of 2005 qualified the needs as ‘immense’.
10 A geographical map of Jonglei State is attached as appendix 10.
2 OBSERVATIONS

This chapter presents an overview of observations made during our visit and from relevant documents (see appendix 6 for an overview). We start by focusing on the limited management capacity of the government at State and County level (2.1), the concept of Lead Agents (2.2) and the need for improved coordination (2.3). Several coordination mechanisms are described at Goss level (2.4) and a State level (2.5). Lastly, we discuss the Project Steering Committee (2.6) as indicated in the original plans (IMA, 2008).

2.1 Limited Management and Implementation capacities

A formal decentralised MoH administrative structure is envisaged in policy documents. In practice the management and implementation capacities of Jonglei State MoH and County Health Departments are seriously constrained. A recent assessment by LATH (2009) found that, although several key policies have been developed and some critical staff have been appointed, in general the health care system in South Sudan is still in its infancy. The LATH study included Jonglei State (see appendix 9 for the results of the Performance Mapping of Jonglei State).

Fig.1 excerpts from Health Performance Mapping: State Ministries of Health South Sudan (LATH, 2009)

"Main identified challenges refer to the implementation of health policies, still to be translated into strategies and action plans; the organisation and financing of SMOH and CHDs; the decision-making, coordination and communication processes between the central and peripheral levels; the management of human resources and the improvement of health services performance and quality standards" (LATH, 2009, p.5)

The assessment further reveals that the quality of health service delivery is generally of low standards, that many health facilities are still non-functional (deteriorated condition, little equipment, no water or power supply). Access to health care is estimated at 25-30% of the total population. The health workforce at State level is dominated by support staff; there is an almost total lack of midwives. All SMOH reported inadequate procurement systems for drugs and supplies. The drug kits provided are standard and not based on real needs in the particular State or County.

The SMOH structure mirrors the MoH-GoSS structure with nine directorates headed by a DG and overseen by the Minister of Health. While most of the director positions are filled, the majority of the positions at lower level remain vacant. A mismatch between actual skills and the requirements of the post is frequent. There appears to be little awareness of State officers of most health policies and a lack of capacity to roll out any policy. Little information is available for realistic planning; the HMIS has yet to be operative.

Our observations in Jonglei State confirm the findings mentioned above on the limited capacity with regard to management and implementation:

- Policies are available, but there is no planning and budgeting cycle in place.
- The State Minister of Health and the Director-General (DG) for Heath are appointed, but many of the directorates are still vacant. The staff appointed do not fulfil the formal requirements. At County level the situation is worse. Therefore the capacity of the State MoH and County Health Departments to manage and coordinate health service provision at their respective levels is very limited.
- In most counties health facilities are present. But we found that only half of the health facilities are operational. Of the operational health facilities several are dilapidated and need serious renovation.
- Drug availability is problematic, immunisation rates are low. For example in Jonglei State the facilities have not received new drug kits since March 2010. As part of a national programme, drugs are intended to be delivered by Government to the County Health Departments, from where they are distributed to all health facilities.

11 Technical Proposal, in response to: Umbrella Program for Health System Development, Lead Agencies to Deliver the Basic Package of Health Services (BPHS) in Selected States – Jonglei (RFP No (MOH-06D/06/GoSS/CS), Form Tech-4.

12 The non-operational facilities have been abandoned at some point in the past, most likely due to security reasons.
2.2 Lead Agents

The Government appreciates the important contribution of NGOs to strengthen management capacities of the State MoH and County Health departments. The MDTF programmes are implemented through Lead Agents (LAs) for each State involved in the project. These LAs are specifically assigned to assist in capacity building of the State MoH and the County Health Department.

The Lead Agents are expected to strengthen health systems at the county and state level to support the BPHS, with the aim to:

- increase access to, quality of, and demand for the Basic Package of Health Services
- increase the capacity of County Health Departments to support and manage the Basic Package of Health services (BPHS) in their respective facilities
  - preparing county health plans, developing the Health Management Information System (HMIS), training health facility personnel, and managing the implementation of priority interventions
- reinforce capacity of the State Ministry of Health (SMOH) to supervise and support the work of County Health Departments.

More specifically the roles of the Lead Agency are to:

1. Build the managerial capacity of the CHDs and technical assistance to the SMOH
2. Build technical capacity of health workers in the facility through short term trainings
3. Effectively sub-contract services to the implementing partners
4. Expand the delivery of the BPHS
5. Increase community activities and involvement
6. Strengthen monitoring and evaluation
7. Innovate and respond flexibly to Challenges
8. Strengthen provision of special health activities: Accelerated Child Survival Initiative (ACSI) and National Immunisation Days (NIDs)
9. Carry out procurement efficiently and effectively with the State Ministry of Health (SMOH)
10. Coordinate health activities in the state with the SMOH

The responsibilities of the Lead Agent also include sub-contracting with local NGOs and Faith-Based Organisations (FBOs) to assist unsupported Primary Health Care Centres (PHCCs) and Primary Health Care Units (PHCUs) to provide priority interventions to their respective communities through outreach and Home Health Promoters.

In 2008 IMA has been appointed as the lead NGO for MDTF implementation in Jonglei and Upper Nile States to spearhead the strengthening of the State MoH and the County Health department. Due to a variety of constraints, programme implementation level is significantly behind schedule with the actual start of the programme in July 2010.

IMA has started with support in the development of annual County Action Plans, especially in Jonglei State. A meeting with NGO representatives is already planned to improve reporting on activities and output (registers, HMIS forms). The work plan further contains several training activities and plans to sub contract several activities. In the meantime an HMIS training by Health Information Systems Programme (HISP) was has been given in Jonglei State. With respect to strengthening coordination mechanisms, in particular the management of a structured, useful and relevant health coordination meeting, IMA does not yet play a leading role. The concept of co-management by both the SMOH and the Lead Agent has also not yet been developed. The delay in the release of funds has seriously constrained the ability of the IMA team to achieve relevant progress in these areas.

Overall, a well balanced and comprehensive programme to establish principle coordination mechanism in terms of planning, budgeting, M&E, reporting and supportive supervision is only at infancy state with a systematic approach to annual work planning is currently being introduced.

13 Taken from "Role of NPA as a Corporate project Sponsor (Lead Agency)"
2.3 Need for NGO support in implementation and in improving coordination

The GoSS Ministry of Health acknowledges the indispensable contribution of non-government agencies to the health sector and emphasizes the need for these actors to continue providing and expanding services in view of increasing coverage of basic health services. The demand for Non-Government agencies to work within the context of emerging Government policies and guidelines and to report on health programme activities carried out at respective levels is clearly articulated in various MoH policy documents: GoSS Health Policy 2007-2011, Strengthening Communications in Health (2010), BPHS (2009). This need is also consistently expressed by government officials at GoSS, State and County levels during our meetings. In the recent past NGO's were used to a virtually non-existent government and therefore had to operate on their own. Now, with government gradually becoming more organised NGO's are expected to work in close cooperation with Government and are expected to abide by Government principles and regulations. The goal of the partnership is to provide the BPHS in an efficient and effective manner to the people of Southern Sudan.

Fig.2 Paragraph on Partnership, taken from the GoSS Health Policy 2007-2011

6.4.2 Partnership

The Ministry of Health recognises the need and importance of working in partnership with health partners in implementing health services. Partnerships support a strategic common vision and approach in implementing and delivering health care to the people. Hence, the Ministry will work in partnership and networking with relevant government institutions, UN organizations, NGOs, FBOs, national organizations, professional associations, communities, private not-for-profit organisations, private for-profit institutions, bilateral and multilateral agencies, the UN organisations, including related organizations as viewed necessary.

Below are some of the strategies proposed by the Ministry of Health to enhance effective partnerships with all stakeholders:

- Ensure that the Ministry of Health at GOSS and State level, and all partners focus on the same vision, mission, goal, and objectives;
- Develop formal and informal coordination and collaboration mechanisms;
- Use the strengths and comparative advantages of health partners;
- Be pro-active with donors and guide them to input selectively to the ministries’ priority programmes;
- Build an atmosphere of trust and transparency;
- Promote policy dialogue, planning and evaluation;
- Promote effective policy communication and coordination.

2.4 GOSS level Coordination

Various coordination meetings between GOSS-MOH and NGOs exist at National level. Next to a regular general NGO meeting at GOSS level, a monthly NGO health forum operates since early 2010 which mainly serves as a forum for exchange of information and a coordinated communication channel with the GOSS MOH. The annual GOSS Health Assembly (GoSSHA) is to bring together health actors such as State Ministries, County Health Departments, NGOs, Donors, Private Sector together once a year. The GoSSHA operates with 5 sub-committees: steering committee, logistics committee, technical committee, finance committee, communications committee.

A National Health Policy outlines the stewardship role of the Ministry of Health. However, a clear framework outlining strategies, institutions and implementation modalities to partner with non-government agencies in the health sector seems not in place.
The introduction of an appropriate modality to improve the coordination at State MoH and County Health Department levels is currently under consideration by the GOSS MoH in consultation with the WHO\(^{14}\). This may potentially provide a national framework for a well defined framework and guideline for health sector coordination in the foreseeable future at respective administrative and implementation levels. The discussion seems to focus not so much on the coordination concepts as such, but on the difference between "health sector" (starting point: MoH) and "health cluster" (starting point: INGOs/UNs). Ministry of Health officials indicated that the health cluster concept does not take the Ministry of Health at various levels as focal point of coordination, but the UN-agencies and INGOs. According to them the health cluster concept seems to include the Ministry of Health merely as one of the stakeholders.

### 2.5 State level Coordination

At Jonglei State, under the Southern Sudan Relief & Rehabilitation Committee (SSRRC), two types of regular meetings are conducted; the monthly inter-sectoral meeting and monthly coordination meetings for various sectors, among which is health. The inter-sectoral meeting mainly serves as a communication forum between the various State line ministries, UN agencies and NGOs. Next to addressing security issues, the meeting is instrumental to exchanging information on programs and activities of individual NGOs in a more general manner and to discuss emergency response activities. At County level, also under the SSRRC, a monthly inter-sectoral coordination meeting is conducted supposedly feeding into the State level SSRRC inter-sectoral meeting. The content of the monthly health coordination meetings is discussed below.

The relationship between NGOs and the SMOH is not clearly specified. The NGO Act states that permission can be given to NGOs to work in Southern Sudan by the Southern Sudan Relief and Rehabilitation Commission (SSRRC) of the Ministry of Humanitarian Affairs at GoSS level. It appears that this authorization (in the form of a certificate) does not involve authorisation from sector ministries such as MoH, nor at GOSS level nor at State and County level. New developments point at the intention to shift authority for granting work permits for NGOs in the Health sector to the MoH. Until then, the relationships between NGOs and line ministries continue to be guided by Memorandum of Understanding (MoU). IMA is currently developing one for subcontracting with NGOs and SMoH.

The LATH study previously mentioned also reported problems because of lack of a formal relation between Government and NGOs at State level. Because of the registration at national level most NGOs also do not feel accountable to the SMOH. Formally, all NGOs are required to show their certificate to the SMOH, but in practice this does not always happen.

These findings were confirmed during our visit to Jonglei State. A monthly health coordination meeting is conducted under auspice of the SSRRC, but chaired by the DG of the State MoH with technical support and input of WHO. In principle all NGOs, FBOs, CSOs involved in health care provision in the State are invited. The minutes of the Health Coordination Meetings indicate that the meeting is mainly a forum to exchange information on activities carried out by the respective agencies. Participation is usually low and limited to the major NGOs that are situated in Bor Town. Purpose and outcome of these meetings in function of an objectively oriented comprehensive health planning and implementation is limited. There seems to be a lack of ownership of the monthly health coordination meetings by the DG State MoH.

Next to the above mentioned frequent and regular meetings, additional ad-hoc and thematic meetings could be conducted under directives from the GOSS MoH in response to emergency situations such as outbreak of endemic diseases or to facilitate new programme initiatives such as the new HIV/AIDS (MDTF) program.

In Central Equatoria State (where NPA is the Lead Agent) regular coordination meetings are held. The meetings are considered effective. The agenda is focused, they ensure that the right persons attend, the frequency is limited and there is clear and systematic follow-up of issues to be addressed. The implementation of the MDTF programme by NPA was not hindered by the delayed release of MDTF-funds, because NPA pre-financed the activities.

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\(^{14}\) Health Cluster Guide; a practical guide for country-level implementation of the Health Cluster.
2.6 Project Steering Committee

The Terms of Reference for this assignment referred to the development of a Health Sector Steering Committee. From the interviews held and documents studied we have understood that the phrasing used most commonly in this context is “Health Sector Coordination Meeting”.

The "Form TECH-4" for Jonglei State entails a graphical representation of the desired management structure (see below).

![Organogram of the Umbrella Programme in Jonglei](image)

The graphical display above includes a Steering Committee. The accompanying text in the document refers to this as an advisory body that will provide official oversight to the State Programme Management Team. Its composition: all active NGOs and FBOs providing basic health service delivery in operational areas will be represented on this committee that will have explicit technical and administrative oversight functions. In Jonglei State this Steering Committee has not been established. This is discussed in more detail in the next chapter (par. 3.2).

NPA did establish a Project Steering Committee in Central Equatoria State. In their setup the primary responsibility of this Steering Committee is to provide guidance to the Project Secretariat in its operations.

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3 RECOMMENDATIONS

3.1 Introduction

This chapter outlines the mission's recommendations to improve coordination of the health sector at Jonglei State level. Recommendations are based on observations as outlined in the previous chapter. A first paragraph (3.2) elaborates on improving the governance structure of the MDTF program, particularly related to the oversight function to keep managers accountable and the programme on track in view of set objectives and priorities. The following paragraph (3.3) deals with more general principles and strategies to improve coordination between multiple health partners in Jonglei State. The final paragraph (3.4) builds on these general principles in providing a set of concrete recommendations with respect to establishment and management of a health sector coordination meeting at Jonglei State.

3.2 Governance of the MDTF Programme

The original focus of this assignment is on establishing Health Sector Steering Committees at State level overseeing MDTF programme implementation. Although mention is made of such committees in the original technical proposals for implementing the MDTF programme, the purpose and TOR of these committees are not clearly articulated. Whereas the functions and position of the State Programme Management Team (SPMT) are properly spelled out, the functions, roles and mandate of the proposed ‘special advisory bodies’ only refer to ‘technical and administrative oversight’. One special advisory body is to oversee the SPMT (the ‘Steering Committee’), a second advisory body is to oversee the County Health Management Team (the ‘County Health Council’). A clear and unambiguous membership composition of these advisory committees is not provided apart for “all those NGOs and FBOs providing BHSP in the operational areas mentioned”. 16

The originally proposed ‘Steering committee’ at State level has so far not been established in Jonglei State, nor have the ‘County Health Councils’ at County levels. 17 Clear ambitions and work plans to establish the mentioned committees in the short term were not found. This may have to do with the general delay in the start of the MDTF programme which has so far made the relevance of these committees less pertinent and obvious. It could be due to the fact that an expertise technical assistance from ETC was needed to undertake development of the system. It may also relate to the lack of clarity in the original plans.

Not surprisingly, the demand of programme stakeholders in Jonglei State was not so much on establishing the original governing concept of the MDTF programme but much more on improving the overall health system, in particular improving general coordination mechanisms of the sector at State and County levels. Subsequently the original focus of this assignment has shifted from establishing specific MDTF programme related Health Sector Steering Committees to accommodate a more pressing issue of overall Health Sector coordination. Nevertheless, in view of the current state of programme implementation as well as the organizational set-up of IMA in support of the MDTF programme in Jonglei State some recommendations with regard to the establishment of a ‘steering committee’ may still be relevant.

Whether or not to setup a MDTF Steering Committee at State level is a choice to be made by IMA and its counterparts. In the present setup, oversight of the programme seems with the IMA management unit in Juba with support from IMA in the United States. Installation of a MDTF Steering Committee would mean transferring some oversight responsibilities from these units to the Steering Committee. Given the limited timeframe of the current MDTF program, the unclarity of its continuation, the limited capacities of Government counterparts at State and County levels, IMA could consider not to establish the MDTF steering committees at State level. 18

Of course in the longer run an executive body like the SPTM would require a Steering Committee for proper guidance and control. In case IMA does prefer to establish a MDTF Steering Committee, it is recommended to do this at National rather than at State level in agreement with the MoH Goss. This may support overall

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16 Refer to Technical Proposals for the umbrella program for health system development for Jonglei State by IMA.
17 The Steering Committee in Central Equatoria State, where NPA is Lead Agent, has been discussed in the last paragraph of the previous chapter (2.6).
18 The current MDTF programme phase comes to an end in December 2011.
programme accountability, coordination, coherence as well as exchange-learning between the two States. The design of this steering committee has to be very specific on roles, mandates and decision making powers and this should reflect composition of its members. Below we suggest primary responsibilities and the membership composition of the Steering Committee. In addition, if considered opportune, then also the Ministers of Health of the two States could be included as member.

**Text Box: Primary Responsibilities of Steering Committee:**

- Guide, oversee the overall implementation of the project plans, budget and operations;
- Receive, review and approve annual & quarterly work plans and budgets;
- Receive and review quarterly & annual progress and financial reports;
- Support and advice the PMU and SPMTs in the running of the project;
- Monitor & Evaluate the performance of the PMU and SPMTs;
- Ensure maximum accountability for effective and efficient programme implementation.

**Text Box: Membership Composition of Steering Committee:**

- The GOSS MOH (Director General PHC): chair;
- World Bank: Representative MDTF Program: member
- Jonglei State MoH (2x): The Director General: co-chair, in turn
- NPA Juba office: Country Director and Health programme manager: member
- Representative County health department of each State: member
- IMA HQ representative US: member
- IMA Chief of Party Southern Sudan: member: secretariat;
- IMA State Team Leaders (2x): member: co-secretariat;

However, next to considering to establish specific MDTF related governance structures, it is recommended that IMA supports and initiates overall health sector coordination mechanisms that comprehensively deal with all programs irrespective its donor whether Government or non-government. The current MDTF programme provides substantial technical support to strengthen State MoH and County Health Departments yet, specific attention to foster general coordination mechanisms are limited and could be more profound as is discussed in the following two paragraphs. Based on experiences in Jonglei State with implementing improved coordination mechanisms, IMA at National level, could document these lessons and share experiences at national level with the aim to contribute to policy development.

### 3.3 General Coordination

Currently, technical and programme coordination of various health care providers is limited and in result health care provision is fragmented. This is due to limited capacities at the various management levels coupled with a substantial number of non-government health care providers working in considerable isolation. IMA, as an appointed lead agent, should take on a specific, proactive and robust role to strengthen Jonglei State MoH in managing and improving a comprehensive approach towards coordination. Similar support to County Health Departments should only be considered if IMA, in collaboration with Jonglei State MoH, has the resources and capabilities to do so

The establishment and functioning of a health sector coordination meeting at State MoH and County health department can be best appreciated in relation to a wider and more comprehensive approach towards improving coordination in the health system between the different levels and between health care providers. Other elements such as e.g. joint participatory planning, supportive supervision, dissemination of information and HMIS (implying an upward flow of data and a downward flow of feedback) are equally important coordination mechanisms in the health system. Although each and every coordination mechanism has specific objectives and are useful in itself, it is recommended to support a comprehensive coordination approach with due attention to improving the various individual elements as they are mutually reinforcing overall coordination in the health sector.

In improving coordination between levels and partners of the health care system, IMA with its partners at State and County level should consider which combination of coordination mechanisms will be effective and
efficient. The outcome of this consideration can be different per State and per County subject to specific characteristics, circumstances and contexts.

Health sector coordination is an important mechanism to engage and commit all relevant health care providers both government as well as non-government. It provides for a unique platform to institutionalize and capitalize on Public-Private Partnerships (PPP). The following principle guidelines are applicable for Public-Private Partnerships: 19

**Text block: Principle Guidelines for Public-Private Partnerships**

1. **Inclusiveness**: Involving all major health service providers of the relevant levels;
2. **Consultation**: A process of reaching collective decisions among stakeholders including views and interest of minority or special interest groups;
3. **Transparency**: Dissemination and sharing of important information;
4. **Facilitation**: Enabling all partners to take part and to take lead;
5. **Efficiency**: Execution of plans and budget in the most optimum manner with regard to available resources;
6. **Empowerment**: Supporting active involvement, engagement and ownership among partners;
7. **Sustainability**: Viable plans supporting longer-term strengthening of the health system;
8. **Accountability and Reciprocal Obligations**: In-build mechanisms for follow-up, check and balances, monitoring and evaluation based on clear distribution and demarcation of roles, responsibilities and duties of partners, possibly reflected in MoUs;

As much as possible, national policies, frameworks, guidelines and implementation modalities for health coordination should be adopted and adhered to. In case these national frameworks and guidelines are too general, they should be amended to match the specific needs and circumstances at Jonglei State and its respective County levels and, in such cases, it is recommended that IMA takes on a leading role. In case national guidelines and frameworks are not existent, lessons could be drawn from other support programmes and projects such as NPA, BFS, etc. In this respect, it is recommended that IMA liaises closely with NPA and BSF and that exchange visits for core technical staff are facilitated.

Ideally, lessons learnt should provide feedback to the GOSS MOH to inform national policy making. Coordination mechanism should as much as possible be aligned with existing structures. The establishment of parallel coordination mechanisms, next to existing ones, should be avoided and discouraged. In case existing coordination mechanism are in place but not efficient, they should be improved upon, preferably in a participatory manner.

Being a lead agent, IMA should try to integrate operations with Jonglei State MoH as much as possible and develop a practical and participatory approach to the concept of co-management. Ideally, IMA is situated in the State MoH office as this will provide many opportunities to give hands-on support, to identify areas for capacity support, to improve cooperation and coordination, to improve mutual understanding and to build rapport with State MoH officials. Next to this, it will increase ownership of managing coordination where it belongs namely, at the State MoH, and will put IMA in a more prominent supporting role as technical advisory unit.

With a focus on improving Jonglei State MoH capacity, IMA should be careful to initiate and improve coordination at the County level as well. Some NGOs, currently involved in direct service provision, may have the potential and ambition to directly support County health departments in co-managing health services, improving coordination and strengthening the health system in general, aimed at delivery of the BPHS using the Primary Health Care approach. IMA is recommended to consider sub-contracting a limited number of “lead NGOs” in support of strengthening County health departments, NGOs could be requested to provide technical, logistical and coordination support to Government health facilities in their catchments areas. Obviously this should be done in agreement with the MOH at the various levels and in consultation with other donors such as e.g. BSF.

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19 Similar principles are in use by the BSF program.
Given the complex social, economic and political environment of Southern Sudan and the interdependencies between various sectors to achieve development including good health, coordination stretches beyond the immediate boundaries of the health sector. It is therefore recommended that IMA keeps an open eye to developmental issues in a wider perspective both at a National as well as local level. IMA should continue to participate and attend inter-agency coordination meetings and should partner with NGOs to improve these meetings in support of a more comprehensive developmental orientation and approach. In addition, IMA could take a supporting role to coordinate and harmonize various capacity support interventions of NGOs to Jonglei State MoH and County Health departments.

3.4 Health Sector Coordination Meetings

Where Health Sector Coordination Meetings (HSCMs) are not taking place (anymore) IMA should take the lead to initiate these with a longer term vision and process approach to strengthen the health system. These meetings should be clearly distinguished and separated from already existing emergency-focused health coordination meetings which are mainly dominated by ad-hoc issues and for which IMA should not take the lead.

A HSCM should not be regarded as an end in itself. Rather, it should be relevant and useful as a means to strengthen the health system and to bring its various important elements into a harmonious and efficient relationship in line with agreed objectives, priorities and strategies. This cannot be done overnight but requires a longer-term multi-annual perspective. Adopting a process approach seems best suited to incrementally improve coordination. Leadership and guidance are important to sustain direction and relevance and to commit and engage partners. Purpose of a HSCM should be clearly articulated and well understood by all partners and give direction to all activities undertaken and priorities set.

The current health coordination meetings under auspice of the SSRRC in Jonglei State level provide the most realistic basis to establish, build and develop a more purposeful HSCM. However, in view of the limited outcomes of these current monthly meetings and the low level of attendance, a convincing effort to re-establish relevant HSCMs is of paramount importance to win support, cooperation and engagement of partners. Objectives, targets, priorities and frequency of a HSCM should be realistic and purposeful. The Jonglei State MoH, with support from IMA, should assume full ownership, take responsibility and be held accountable.

Given the serious capacity constraints and limitation of Jonglei State MoH and County Health Departments, the HSCM should be particularly relevant as a mechanism to improve functionality and output of Jonglei State MoH and its respective County Health Departments. Moreover, the HSCM should support partners to improve executing their respective individual programs more effectively and efficiently. Support and possible areas for improved collaboration and cooperation should be focused on an enabling health care system for the provision BHSP and the improvement of fundamental systems such as logistics, drug supply, procurement, basic training, supervision, inspection, etc. As much as possible, the HSCM should contribute to facilitating partners in the execution of their respective programs.

Next to this, it is recommended that the HSCM should be purposeful in direct support of establishing an annual health planning cycle for Jonglei State MoH and County Health Departments and all implementing partners. Preparation and consolidation of annual plans and budgets as well as monitoring and evaluation of these plans could take place in the context of the HSCMs. At a later more advanced stage, the HSCMs could be used to also facilitate multi-annual strategic plans.

A third important function for an HSCM is the dissemination of relevant documents, guidelines, protocols and leaflets to help guide and facilitate partners in the execution of their programs and to establish standards.

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*The use of “lead agents” at county level is currently being implemented by the Basic Service Fund (BSF). As the BSF programme has contracted some NGOs to be lead agent in a number of Counties in Jonglei State, it is recommended that IMA seeks coordination with BSF and studies the modalities, frameworks and MoUs in use.*

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20 The actual implementation is subject to phase 3 of this assignment, which will be based on specific guidelines and a training approach designed in phase 2.
Improving health sector coordination

for quality of care. In view of this important function, it is recommended that IMA initiates and supports the collection of available information, policy documents, guidelines, protocols, health data and socio-economic information and to bring all this information together and to establish an information and resource centre at the State MoH. Supportive complementary initiative could be considered such as initiating an e-mail newsletter for all partners at a regular interval.

Opposed to the current monthly meetings, it is recommended to limit HSCMs to a maximum of 3 or 4 per year. This will partly depend on capabilities of Jonglei State MoH to prepare, facilitate and manage follow-up. Frequency of conducting HSCMs should be realistic and purposeful. It should take into account that most participants have to travel considerable time and need to attend many other meetings as well. Scheduling of meetings should accommodate participants work programmes, transport and logistical constraints and as much as possible in function of a purposeful agenda. A realistic budget should cater for transport and overnight expenditures of participants.

Participants of the HSCM should be all those organizations directly or indirectly involved in health care service provision at Jonglei State and County levels both from Government as well as non-government. As the HSCM is a technical forum - not a political one - participants should be health professionals. Since the HSCM coordinates and decides on health planning and budgets, participants should be well informed and have authority and mandate to take decisions on behalf of the organization they represent. The number of participants can vary but should be limited as to accommodate useful and workable meetings. Rather than including all NGOs it is more realistic to select a group of representative NGOs. Of course all NGOs will be kept informed about the issues discussed and actions taken. As it is not recommended to start with health coordination meetings at County levels, representatives of the County health departments as well as leading NGOs from each county should participate in the Jonglei State MoH HSCMs. As ownership of HSCM is with the State MoH, the Director General of State MoH should chair the HSCMs, possibly with support from IMA.

**Text Box: Proposed Participants of HSCM**

- Jonglei State MoH: Director General (Chair);
- Jonglei State MoH: Director of PHC, Director of Curative Services, Director of Human Resources (Deputy Chair);
- IMA Team Leader & Deputy Team Leader (Secretariat);
- State level major/lead International NGOs (e.g. WHO, Unicef, WFP, etc.);
- County Health Department Officer (all counties);
- County lead NGO (International or Local) receiving funds from IMA through sub-contract;
- I/C of Jonglei State Hospitals
- I/C of County Hospitals

HSCMs should be properly prepared, facilitated and followed up directed by a clear and purposeful agenda along the principles outlined above and agreed upon by all participants under chairmanship of Jonglei State MoH. It can be envisaged that separate project groups could be established for the purpose of following up and working on specific technical issues identified. In such cases, specific TORs and realistic target outputs should be defined for each working group. Project groups should preferably be chaired by the relevant State MoH department under which the subject matter resorts. If need be, IMA should act as secretariat in support of State MoH. A budget to facilitate the project groups should be agreed upon and set aside including possible liaison with GOSS MoH.

Coupled with establishing HSCMs and in order to follow-up on action points emanating from these meetings, it is recommended that IMA initiates a structured, monthly and focused scheme of supportive supervision. Supportive supervision should become an integral function of Jonglei State MoH. A clear TOR for supportive supervision should be agreed upon and mandated by GOSS MOH in relation to roles and responsibilities of the respective levels in a decentralized healthcare system. In general terms, the supportive supervision of the State MoH should assist the County health departments to help oversee, guide, facilitate and control health facilities and programme implementation of partners.
4 PROPOSED WAY FORWARD OF THE ASSIGNMENT

4.1 Introduction

This chapter elaborates on phase 2 and phase 3 of this assignment. A first paragraph (4.2) elaborates on the proposed preparatory period to arrange tools and guidelines. The following paragraph (4.3) lists the most important objectives, outputs and methods for implementing phase 3 of the assignment.

4.2 Phase 2

Phase 2 of the assignment is to take place in October 2010. Based on recommendations in this report and in preparation to help IMA strengthen the general coordination mechanisms for the health sector and to establish and manage regular and purposeful health sector coordination meetings, a preparatory phase is still required. The main objective of this phase is therefore to develop appropriate and practical tools, protocols, methodologies and approaches that guide this facilitation process that will take place in phase 3 of this assignment.

As a basis for engaging in phase 2 comments and suggestions from all relevant parties are sought concerning the recommendation of this report. This applies particularly for the proposed broadening of the focus of the TOR from supporting the establishment of HSSCs to support general coordination in the health sector aimed at delivering the BPHS using the Primary Health Care approach and with an emphasis on establishing regular and purposeful HSCMs at State level.

The plan to introduce a HSCM needs the full cooperation of the DG-MoH, the SSRRC-representative in Jonglei State and other main stakeholders such as the WHO-representative. This means that this report and more specifically the plans for introducing the HSCM need to be discussed with the three officers mentioned. Where necessary the plans can be adjusted to ensure their full cooperation. The consultants are ready to prepare this discussion by drafting a Powerpoint presentation about the proposed plans and mechanisms.

This report on phase 1 together with the comments and suggestions will form the starting point for phase 2. A detailed set of outputs regarding facilitation of this process shall be prepared and communicated with IMA.21 The following outputs for phase 2 are proposed (see text box next page):

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21 Existing tools may be used where relevant or appropriate (e.g. Training modules for Health System Strengthening of health District teams (IMA World health), WHO, etc.).
Phase 3 of the assignment is scheduled for November 2010 but the data need to be agreed on by all stakeholders in this process. The 3rd phase of the assignment will have a twofold objective of:

**Text Box: Objectives & Outputs Phase 3:**

1. Sensitizing and training key Jonglei State MoH actors on: (a) Health Sector coordination in general and; (b) establishing & managing regular HSCMs;
2. Facilitating the start of a HSCM in Jonglei State, in which the issue of health sector coordination will be the central topic of the agenda. Participants would be as explained in the text box at p.19.

The interactive training and sensitization workshop for Jonglei State MoH staff (Director General, directors of PHC and Curative Departments) shall be used to prepare for the launching of the 1st HSCM and has the character of a hands-on and on-the-job coaching. We would like to suggest the option to hold a joint preparatory workshop\(^\text{22}\) with participants from Jonglei and Upper Nile State to provide opportunities for exchange of experiences and cross learning. The venue of this preparatory training could be Juba after which, HSCMs will be conducted in both States separately, also with facilitation and support from the ETC team. Planning for these activities need to be done well before November and involve all those key actors and partners that are supposed to take part in it.

\(^{22}\) We understand that the preparatory workshop can only be organized jointly in case IMA supports this plan financially.
APPENDICES

Appendix 1 Memorandum of Understanding between ETC Crystal and IMA World Health
Appendix 2 SuddHealth TOR for ETC June 2010
Appendix 3 Concept Paper "Technical Support to health Sector Steering Committees (HSSC)
Appendix 4 Sub-Grant Agreement Final IMA – ETC CRYSTAL
Appendix 5 Resource Persons
Appendix 6 Resource Documents
Appendix 7 Itinerary
Appendix 8 NGOs Operational in Jonglei State
Appendix 9 Performance Mapping Jonglei State from LATH report
Appendix 10 Map of Jonglei State
MEMORANDUM OF UNDERSTANDING
Between

ETC Crystal
Leusden, the Netherlands

and

IMA World Health
New Windsor, Maryland USA

Preamble
This memorandum between ETC Crystal and IMA World Health establishes the broad mutual understanding of our two organizations regarding our strategic relationship in establishing and operating programs in South Sudan, following our successful bidding for an MDTF contract for two states (Jonglei and Upper Nile). We recognize the autonomy of each organization and enter this agreement in a spirit of mutual trust, respect and a shared commitment for social justice and the preferential option for the poor. This Memorandum of Understanding is therefore a statement of mutual intent to which the two organizations are bound at a minimum for the duration of the contract concluded between IMA and the Ministry of Health/WB. For specific jointly developed programs, separate sub-agreements will be entered into in the form of grant agreements or other documents based on specific program plans and budgets.

1.0 Organizations to the Memorandum of Understanding
1.1 Organizations to this Memorandum of Understanding are ETC Crystal (ETC) and IMA World Health (IMA) respectively, herein after called the organizations.

1.2 This MOU does not preclude each organization from working independently with other organizations in South Sudan engaged in health development activities. However, the organizations shall be transparent about the establishment of these collaborations with other organizations, in as far as they affect the collaboration between ETC and IMA.

2.0 Identity of the Organizations
2.1 ETC and IMA affirm that they are both autonomous organizations with common goals. The parties shall therefore work together to fulfill their common goals while affirming their different identities.

2.2 Guiding Principles of ETC Crystal
a) To promote equitable and sustainable health sector development by strengthening the capacity of local institutions and organizations through a process in which all relevant actors have an opportunity to participate.
b) Participation of target groups in program design and monitoring/evaluation is a prerequisite to safeguard the program’s efficacy and sustainability.
c) Recognition that health has many determinants including good governance, education, opportunities for economic development, gender relations, climate conditions and HIV/AIDS, all which affect people’s health and determine the scope for strengthening health systems in a sustainable manner.
d) Adherence to the principle of equity, through the emancipation of less privileged groups in society, both in terms of benefit and participation in the design, implementation and monitoring of health programs.
e) The need to increase the credibility of health service providers by improving the quality of care and strengthening health sector governance.
f) Promotion and nurturing of home-grown solutions adapted to local circumstances and capacities with mediation and facilitation of consensus when required.

g) Collaboration with local consultancy firms and individual experts to ensure socio-cultural viability and long-term sustainability of health programming and health sector development.

2.5 **Mission Statement of IMA**

To provide essential products and services for emergency, health, and development programs of interest to members, which serve people in need without regard to ethnicity, color, gender, national origin, age, religious, or political affiliation.

2.6 **Guiding Principles of IMA**

1. **Faith** directs IMA World Health's activities from a Christian perspective, with an ecumenical spirit, in service for and with God.
2. **Integrity** underlies IMA’s dedication to nurture mutual respect, honesty, transparency, and commitment in all partnerships, and to uphold its core principles in all activities.
3. **Justice** requires IMA to promote policies and programs that foster equality, advance peace and harmony, and respect the basic human rights of all people.
4. **Solidarity** directs IMA work towards a paradigm of unity, working together with partners and recognizing our common aim to promote health of body, mind, and spirit for the benefit of all in the global community.
5. **Accountability** requires IMA to build systems with all partners to maintain effective checks and balances to provide honesty and transparency.
6. **Ownership and empowerment** are principles with which IMA seeks to build, promote, and nurture development activities of implementing partners.
7. **Sustainability** means that IMA programs seek to ensure an enduring benefit with local control and funding.
8. **Assessment, Monitoring, and Evaluation** are the tools with which IMA and partners will carefully examine the potential benefits and risks, track progress, and measure outputs.
9. **Partnership** depends on collaboration and coordination with both domestic and overseas partners in an open, transparent, and respectful manner.

3.0 **Goal and Values of the Collaboration**

3.1 **Goal:**

The organizations shall work together, each according to the means it can contribute, for the development of the people of Southern Sudan while enhancing their respective capacities and that of their partner institutions, providing health services in South Sudan.

3.2 **Values:**

The organizations recognize they have a common vision, for addressing people's immediate primary health care needs and the underlying causes of suffering and injustice with peace and restoration of human dignity, promotion of self-reliance and sustainable development, addressing the needs of the poor, and an integral approach to mitigate human suffering.

The organizations commit themselves to a relationship based on values including: complementary relations and mutuality, equitability, openness and sharing, mutual transparency, sustainability, community participation, strengthening civil society and mutual capacity building.

4.0 **Operating Principles**

This Memorandum of Understanding shall be based upon the following operating principles:

4.1 **Structure**
The organizations shall utilize and strengthen already existing local structures on the ground in the two states in South Sudan (Jonglei and Upper Nile).

4.2 Implementation
Local structures shall be the primary implementers in undertaking programmatic activities.

The organizations shall complement each other in the process of implementation of programs in full recognition of the requirements of being accountable to donors, communities and other stakeholders.

4.3 Decision-Making
Decisions affecting the partnership will be made by mutual consent. One organization can not make a decision affecting the other organization without its consent. All organizations have the right to submit proposals that involve a mutual decision and will respect the particular characteristics of each organization and its right to mutual consent.

4.4 Programs
Concrete joint program initiatives will be undertaken in the spirit of the present MoU, based on progress in implementing the MDTF framework contract and at the initiative of either party as per perceived needs. Each such joint program initiative will be specified and governed by an addendum or sub-agreement which will be appended to the MOU. In principle, the addendum/sub-agreement will comprise of a terms of reference specifying the technical nature of the initiative and the expected output (deliverables), as well as the financial arrangements.

The organizations shall respect initiatives from other development players and advocate for information-sharing at all levels.

The organizations shall share the responsibility to take a participatory and holistic approach to technical issues and program quality.

4.6 Communication
The organizations shall advocate for open communication between each other and other institutions at all levels and shall be committed to the ownership of the relationship thus equally bearing the responsibility for initiating the communication process.

4.7 Solidarity
Each organization undertakes the following:

- To find flexible and mutually agreeable solutions to situations beyond the control of either organization that affect program implementation (e.g. social/political conflict, natural disaster, etc.)
- To actively seek the way to build mutual trust by fully sharing information and problems with the other organization.
- To recognize and respect other stakeholders to which each organization is accountable (e.g. communities, donors, etc.)
- To periodically review their partnerships jointly and continually seek ways to nurture and strengthen it.
- To comply fully and promptly with the conditions of any projects involving the other organization and to act in a fiduciary relationship with mutual respect.
- If one organization believes that another organization is not living up the MOU, the first organization will communicate this to the other organization.

5.0 Organizations individual contributions
Both ETC and IMA are committed to building a collaborative institutional relationship by sharing their respective experiences and expertise.
Each organization agrees to share their respective materials and approaches in an attempt to develop new materials or approaches, or enhance existing ones.

Each organization will contribute to this relationship the following:

**ETC**
- Health systems support in the form of short-term consultancies:
  - Development of health programs
  - Elaboration of funding proposals
  - Technical backstopping, both in situ (in the field) and at a distance (e.g. providing written feedback on programmes, funding proposals, technical reports)
  - Studies
  - Facilitation of internal reviews
  - Evaluation/reviews
- Training design:
  - Public/Private sector collaboration
  - Civil partnerships for social development
  - Technical health training

**IMA**
- Access to Financial assistance
- Access to Commodities
- Facilitation of relationships—US-based development community, US churches and church bodies, donor community particularly USG and pharmaceutical partners
- USAID Mission, World Bank and other stakeholders
- Technical expertise, particularly in the area of health system strengthening
- Expertise in facilitation of program implementation

The nature of support (consultancies or trainings), its planning, etc. will be included in the semi-annual operating plans, facilitated by adequate provision in the operating budgets. Separate sub-agreements will guide specific contributions made by ETC Crystal.

6.0 **Conflict resolution**

6.1 We enter into this MOU in a spirit of mutual trust and intend that all unforeseen matters on issues that arise, as the relationship evolves, will be resolved in a spirit of mutual understanding.

6.2 In the event that there is a conflict it shall be resolved in a peaceful and amicable manner. Every effort will be made to settle the matter through dialogue and negotiation and to accommodate the policies and intention of each other’s respective administration, boards, donors and constituents.

7.0 **Consultative Committee**

A Bi-Annual Consultative Meeting will be established in the spirit of the MOU. The meeting will comprise two members of each of the four main consortium partners. It will give direction to the collaboration by establishing an agenda (and reviewing progress. If possible, the Consultative Meeting will physically meet in Nairobi or Juba (or another convenient place). Otherwise, the committee will deliberate through a group telephone conversation.

8.0 **Modification of the MOU**

This MOU shall be subject to annual review by the ETC Crystal Managing Director and the IMA World Health South Sudan Representative, or by a future Consultative Committee to strengthen cooperation between the two organizations.
9.0 **Period of Memorandum of Understanding**

This MOU shall remain in effect until changed or terminated by either organization through mutual consent.

10.0 **Withdrawal from the Memorandum of Understanding**

This MOU shall remain in effect until changed or terminated by either organization through mutual consent.

11.0 **This Memorandum of Understanding is effective on July 1, 2008 upon signing.**

Signed:

Jos Dusseljee, Manager
ETC Crystal
Leusden, the Netherlands

[Signature]

October 8, 2008
Date

Paul Derstine

[Signature]

Paul Derstine, President
IMA World Health
New Windsor, MD, USA

September 8, 2008
Date
1.0: Background:

In early October 2009, IMA World Health met with the Ministry of Health-GoSS in Juba to negotiate a “Revival Plan” that would run through June 2010 and support forward implementation of the MDTF-BPHS for Jonglei and Upper Nile States. As part of this endeavor, IMA also met individually with Technical Partners – CHAS and ETC Crystal. One significant outcome of the partners’ meeting was the consensus to hold a deliberation with partner members in November 2009 to plan the program activities for 2010. This meeting took place duly on November 20th-21st, with the following main objectives:

1. To organize the partners (CHAS, TICH and ETC Crystal) in reviving the implementation of the SuddHealth Projects;
2. To review the status of the 3 years work plan and budget;
3. To define roles and responsibilities of the partners for various project activities.
4. To organize the technical workshop to train CHD Teams on management of Primary Health Care.

2.0: Project Evolution:

At the same time as the Revival Plan was being negotiated, MoH-GoSS and WB introduced major changes in the duration, funding level and objectives of the MDTF project effecting major shifts and revisions in contractual conditions – the major change being working in all counties instead of only six per a state as initially proposed. Given the significant shift in focus, IMA and partners felt it necessary to streamline the understanding, budgeting and implementation strategies for the project to include the following major components:

- **Component A**: Increase access to, quality of, and demand for the Basic Package of Health Services;
- **Component B**: Increase the capacity of the CHD teams to support and manage the BPHS in their respective health facilities; and
- **Component C**: Reinforce capacity of the State Ministries of Health (SMOH) to supervise/support the work of CHD teams.

On the realization that the shift to “working across all counties with targeted interventions” would have serious implications in terms of developing a revised budget compatible with the revival plan as it would be impossible to assist 23 counties (11 in Jonglei and 12 in Upper Nile States) with the level of assistance originally planned for SuddHealth, it was decided to customize the level of project funding by county taking into account the assistance provided by other development partners and to concentrate on fewer interventions. The following 3 levels of assistance were proposed:
- **Global Assistance**: to counties that are currently completed unassisted counties. This would include personnel incentive support for all (or most) HF.

- **Partial Assistance**: This would include personnel incentive support for unassisted health facilities, e.g., perhaps 50% of facilities.

- **Targeted Assistance**: to all counties to support priority BPHS interventions:
  - Child Health: Immunizations
  - Nutrition: Vitamin A supplementation
  - Malaria: IPT and routine ITN distribution at ANC
  - Maternal Health: Ante-natal, safe delivery and post-natal services
  - Family Planning: Child spacing
  - Behavior Change Communication/IEC: Water/sanitation, exclusive breastfeeding, prompt care seeking, child feeding, and HIV/AIDS.

A draft list of these technical components, along with anticipated level of funding for January to June 2010 was discussed. Each technical partner was asked to identify 1-2 components of the project they are interested to work on and the outcome was as follow:

- **CHAS**: proposed to support targeted interventions at the community level e.g., training of Health Homecare Providers (HHPs), refresher training of health staff which would include developing BCC/IEC strategy and ToT for local training of HHPs, as well as, conducting KPC & LQAS studies (“Component C”).

- **TICH**: opted to work towards formation of “health facility committees” or “health catchment area committee” and capacity build CHD teams (“Component B”).

- **ETC**: agreed to take the lead role in developing the conceptual framework and guidelines for creating State level Health Sector Steering Committees (HSSC) and in planning workshops to ensure HSSC links to County Health Councils (“Component C”).

- **HISP&JHU**: would develop HMIS system and train staff on data processing and the aspects of management at CHD, SMoH, and Central levels.

With the above proposals on the table, the division of labor for Component C was concluded. The suggestion for the "next step" was for each technical partner to develop a more detailed Scopes of Work" for each of the major activities of Component C that they proposed to lead on. It was agreed that each partner designated a "Lead Role" for a particular activity prepares a short "concept paper" for that activity describing: 1) the strategy proposed, 2) main tasks to be conducted and 3) budget estimates based on the level of budget allocated.

**3.0: Recent Changes:**

Besides the earlier changes that took place in late 2009, there are also some more recent changes which have been effected by MoH-GoSS in March 2010 during the negotiation of the revised SuddHealth Contract. These changes having important implications in terms of the funding level available to each technical partner, mainly relate to the following:

- **Removal of partners overhead cost**: Although IMA initially presented overhead costs as percentage (25%) of various subtotals for the technical partners (CHAS, TICH and ETC), MoH-GoSS instructed IMA to remove these management costs from the budget, insisting...
that partners should receive funding only for the activity they will implement. This will obviously impact on funding levels for the partners.

- **Removal of HISP/JHU consultancy for State to Central level HMIS:** During the negotiations, IMA was informed that the implementation of the State-Central level HMIS will now be provided by LATH under their MDTF contract agreement and that IMA should removed that portion of activity from its current budget.

- **Removal of BCC/IEC activities from CHAS:** During contract negotiation, MoH-GoSS instructed IMA to remove from project budget the funds allocated to CHAS for developing BCC/IEC materials and conducting the campaigns and suggested IMA staff should undertake these responsibilities as part of their normal project activities.

Given the encouraging news of June 11th that the initial disbursement of the SuddHealth Project is now available, IMA and technical partners must gear up for project implementation. The best place to start is where we stopped. The following section outlines the activities that ETC Crystal as SuddHealth technical partner must elaborate on in order to move forward with implementation of the “Component C” activities it has previously agreed to lead on during technical partners meeting of Nov, 2009.

**4.0: Scope of Work:**

ETC Crystal is hereby requested to prepare and present to IMA within one week of receipt of this TOR (i.e. by July 1st), a short "concept paper" of 1-3 pages on development of framework/guidelines for operating State level Health Sector Steering Committees (HSSC) and conduct of workshop to ensure HSSC links to County Health Councils (“Component C”) as it proposed to undertake, outlining clearly:

1. The strategy proposed to achieve objectives of the assignment;
2. The methodology and tools for developing operation framework/guidelines for state level HSSCs;
3. The methodology and tools/materials for training the HSSCs;
4. The costed detailed activity plan based on the level of funds indicated in Annex 2 – showing clearly the activities & budget requirements for the next 3 months as of July;
5. The main tasks and project outcomes to be accomplished;
6. The time line for project implementation.

**5.0: Resource & Documents IMA will Available:**

Annex 1: Copy of 2008 MoU signed between ETC Crystal and IMA World Health;

Annex 2: Budget available to ETC Crystal for its assignment in Jonglei & Upper Nile;

Annex 3: SuddHealth project work plan for Jonglei State

Annex 4: SuddHealth project work plan for Upper Nile States;
6.0: Next steps:

1. Following feedback from ETC Crystal and other technical partners (CHAS and TICH), IMA will convene one planning meeting with the partners to review and finalize detailed activity plans for all components of the SuddHealth projects;

2. During this planning meeting, IMA will also share with technical partners the templates for monitoring their Technical/Programmatic activities and Financial Expenditures. The schedule or modality of funds transfer to technical partners will also be discussed.
SUDDHEALTH PROJECT
STRENGTHENING HEALTH SYSTEMS SOUTHERN SUDAN

TECHNICAL SUPPORT TO HEALTH SECTOR STEERING COMMITTEES (HSSC)

CONCEPT PAPER
6th July 2010
TABLE OF CONTENT

1. INTRODUCTION ......................................................................................................................... 1
  1.1 Background .......................................................................................................................... 1
  1.2 Proposed Strategy .............................................................................................................. 2
  1.3 Proposed Timeframe .......................................................................................................... 4
  1.4 Proposed experts ................................................................................................................ 5
  1.5 Budget (in USD) ................................................................................................................. 6
  1.6 Annexes .............................................................................................................................. A
1. INTRODUCTION

1.1 Background

The SuddHealth Project is implemented by a consortium consisting of IMA Worldhealth, CHAS, TICH and ETC Crystal. In November 2009, a consortium meeting was held in Juba (21-21st November) to discuss the status of the project and to chart the way forward. The three major components were discussed:

- Component A: Increase access to, quality of and demand for the Basic Package of Health Services (BPHS).
- Component B: Increase the capacity of the County Health Department (CHD) teams to support and manage the BPHS in their respective health facilities
- Component C: Reinforce capacity of the State Ministries of Health (SMOH) to supervise and support the work of County Health Department teams.

In the November 2009 consortium meeting it was agreed that ETC Crystal would take a lead role in developing the conceptual framework and guidelines for creating State level Health Sector Steering Committees (HSCCs) in Upper Nile and Jonglei States and in workshops (e.g. planning or stakeholders) to ensure the HSCC links to County Health Councils. This approach is part of Component C.

Based on the Terms of Reference (TOR) and the Scope of Work, ETC Crystal has prepared a short “concept paper” to outline:

1. The strategy proposed to achieve objectives of the assignment;
2. The methodology and tools for developing operation framework/guidelines for state level HSSCs;
3. The methodology and tools/materials for training the HSSCs;
4. The costed detailed activity plan based on the level of funds indicated in Annex 2 – showing clearly the activities & budget requirements for the next 3 months as of July;
5. The main tasks and project outcomes to be accomplished;
6. The time line for project implementation.

In addition, CVs of proposed consultants and a detailed budget (Excel) have been attached to the concept paper.
1.2 Proposed Strategy

Objectives

The objectives for the assignment are:
2. Conducting workshop(s) to ensure effective HSSC links to County Health Councils in the two States.

Point of departure

The proposed strategy to achieve the objectives for the assignment will take into account that the two HSSCs are two new governing bodies at State level that will need to be established in a specific institutional setting and with a clear composition, role and mandate.

As far as could be established from resource persons in the public and private health sector in Sudan, the current policy framework for the health sector in Southern Sudan does not provide concrete guidance regarding the institutional setting, role and mandate of the HSSCs. This fact will be a point of departure in the proposed strategy.

Phase 1: Exploration and assessment and main tasks

In phase one it is proposed to focus on exploring the current situation and assessing the options for a successful establishment of HSSCs. A team of two senior persons (Dr. Albert Beekes and Mr. Pieter Gunneweg) will explore the following aspects:
1. Document review of the IMA Sudd health documents prepared since 2008 with a focus on matters that are relevant for the establishment and functionality of the HSSCs.  
2. Document review of the Government Policy Framework for South Sudan (e.g. Health, Local Government, Decentralization, Policy and Planning, Finance) with a focus on matters that are relevant for the institutional setting, funding mechanisms, roles and mandates, legal position of the HSSCs.
3. Investigate examples of similar institutions in other sub-Saharan countries which may serve the development of HSSC.  
4. The document review will lead to the identification of key areas that will need to be explored further in Sudan at Juba (National) and State level.  
5. In-depth discussions with Juba based key resource persons from: (1) IMA Worldhealth, (2) GOSS-Ministry of Health, (3) Ministry of Policy and Planning, (4) Ministry of Local Government, (5) Ministry of Finance, (6) International donor agencies, (7) Norwegian People Aid (NPA) as MDTF Lead Agent in Central Equatoria and (8) relevant International NGOs working in the health sector. The focus will be obtaining relevant information for the institutional setting, funding mechanisms, roles and mandates, legal position of the HSSCs.  
6. Field visits to Jonglei and Upper Nile State to meet with the IMA Worldhealth teams at State level, the State MOH representatives and State Government officials from other-relevant- departments, representatives from County Health Departments (CHDs) and representatives from International NGOs working in the health sector. The focus will be on assessing options to compose HSSCs, build up capacity of HSSC, capacity building needs and most suitable training methodology, institutional setting, funding mechanisms, roles and mandates and legal position.

The exploration and assessment phase will be participatory making sure that a cross-section of relevant actors at State and County level, both government as well as non-government, will have a chance to share ideas about and contribute to the establishment of the HSSC.
The outcome of phase 1 will be a detailed report that presents the findings of the exploration and assessment phase and that will come up with recommendations and a roadmap for the second and third phase.

Phase 2: Development of a framework, guidelines and capacity building plan for HSCCs and main tasks

It is proposed that phase two will be implemented in the Netherlands. The team that carried out the phase 1 visit will carry out the following activities:
1. Preparation of a draft framework and operating guidelines for the HSSCs. Important elements of this framework will include:
   a. The institutional embedding of the HSSCs both in relation to its functions and mandates with regard to the National level, State level and County level.
   b. Roles and responsibilities, composition of members, selection of members, tasks of the members, participation in planning and budgeting activities, participation in support supervision.
   c. Operational modalities.
2. Assessment of suitable training tools for the capacity development of the HSCCs. The Training Modules for Health System Strengthening of Health District Teams (IMA work Health 2009) will be assessed as well as training modules from (1) Tanzania DANIDA/MOH programme (Capacity building of Regional Health Management Teams and District Health Management Teams) and (2) Kenya/ETC Crystal/DFID/SIDA MOH support programme.
3. Development of a capacity building programme for HSCCs to be implemented in phase 3.

The outcome of phase two will be:
- A draft Framework and operating guidelines for the HSSCs.
- A capacity building and training plan for the HSSCs.
- A set of training tools for the HSSCs.

Phase 3: Capacity building and training and main tasks

The third phase will focus on the actual training of the two HSSCs in Upper Nile and Jonglei States. A team of two senior persons (Dr. Albert Beekes or Dr. Loan Liem and Mr. Pieter Gunneweg) will train the HSSC members in a range of topics. Although the precise approach and tools will still need to be developed, it is foreseen that the training will focus on the following areas:
- Policy Framework Health and other –relevant- Ministries.
- Institutional setting, legal setting and Organogram.
- Composition of HSSCs and selection of members.
- Roles, Responsibilities and Mandates of members in the State health sector.
- Linkage to and interaction with SMOH and CHDs.
- Public Private Partnerships and modalities for effective collaboration.
- Planning and Budgeting modalities in the context of decentralized Government.
- Resource mobilization from 2011 onwards (post Referendum phase).
- Supervision, Monitoring and Evaluation.
- Sustainability of the HSSCs.

It will need to be discussed whether this training will be combined for the two HSSCs in one location or whether the training will take place at State level for each HSSC.
The training will follow an approach that will allow for Action Learning (Using the day to day work practice for reflection and learning) and will ensure a participatory and interactive approach with ample room for practical exercises.

The outcome of phase 3 will be a training report based in the training provided to the two HSSCs.

1.3 Proposed Timeframe

The proposed time frame is designed as follows:

<table>
<thead>
<tr>
<th>Period 2010</th>
<th>Core Activities</th>
<th>Persons</th>
<th>Days</th>
</tr>
</thead>
</table>
| 19th August-18th September | Phase 1 core activities (by 2 persons).   | Dr. Albert Beekes  
Mr. Pieter-Paul Gunneweg | 20 days  
20 days |
|                    | • Preparation will start on 19th August (2 days).   |                                |         |
|                    | • Travel can take place from 22nd August-4th September (14 days).  
This is the period for meetings, field visit and debriefing. |                                |         |
|                    | • Report writing will be done after the mission (4 days). |                                |         |
| October (dates to be defined). Netherland based. | Phase 2 core activities (by 2 persons).   | Dr. Albert Beekes  
Mr. Pieter-Paul Gunneweg | 2 days  
8 days |
|                    | • Preparation of framework and guidelines.                  |                                |         |
|                    | • Development of training programme and tools             |                                |         |
| November (dates to be defined). Sudan based. | Phase 3 core activities (by two persons).   | Dr. Loan Liem  
Mr. Pieter Paul Gunneweg | 20 days  
20 days |
|                    | • 2 days Preparation                                      |                                |         |
|                    | • 14 days field visit and training.                       |                                |         |
|                    | • 4 days report writing                                   |                                |         |
| Backstopping (Netherland based). | Technical support to the team and co-reading of draft documents | Mr. Jos Dusseljee  
Ms. Patricia Schwerzel | 2 days  
2 days |
1.4 Proposed experts

For the team that is proposed, the CVs have been attached. All the persons proposed have a long-term working experience in Africa. The persons that will be involved in this assignment include:

1. Dr. Albert Beekes: A senior sociologist and health system management specialist with a focus on Institutional development, System Development, Finance and Public Private Partnerships.


3. Dr. Loan Liem: A senior Medical Doctor specialized in Fragile States, Health Recovery Systems and Capacity Development.

4. Mr. Jos Dusseljee: A senior Management Advisor with a long-term experience in Institutional Development and Programme Management. Has been involved in the SuddHealth programme since its inception.

5. Mrs. Patricia Schwerzel: A senior Health Advisor with a long-term experience in Sudan, Capacity development, Public Private Partnership and Resource mobilization. Has been involved in the SuddHealth programme since its inception.

It is proposed that the first three persons (Beekes, Gunneweg and Liem) will carry out the main assignments. The other two persons (Dusseljee and Schwerzel) will provide backstopping support.
### 1.5 Budget (in USD)

**Project no.:** Acq4004  
**Project name:** Capacity building of Health Sector Steering Committees and County Health Councils

#### Time spent Jonglei State

<table>
<thead>
<tr>
<th>Name expert</th>
<th>preparation</th>
<th>mission*</th>
<th>reporting</th>
<th>total</th>
<th>fee</th>
<th>amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albert Beekes</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>11</td>
<td>875</td>
<td>9,625</td>
</tr>
<tr>
<td>Loan Liem</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>10</td>
<td>875</td>
<td>8,750</td>
</tr>
<tr>
<td>Pieter–Paul Gunneweg</td>
<td>2</td>
<td>18</td>
<td>4</td>
<td>24</td>
<td>875</td>
<td>21,000</td>
</tr>
<tr>
<td>Patricia Schwerzel</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>875</td>
<td>875</td>
</tr>
<tr>
<td>Jos Dusseljee</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>875</td>
<td>875</td>
</tr>
</tbody>
</table>

* 5 'mission' days in the Netherlands  

Total: 47 days, fee: $82,250

#### Time spent Upper Nile

<table>
<thead>
<tr>
<th>Name expert</th>
<th>preparation</th>
<th>mission*</th>
<th>reporting</th>
<th>total</th>
<th>fee</th>
<th>amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albert Beekes</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>11</td>
<td>875</td>
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<tr>
<td>Loan Liem</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>10</td>
<td>875</td>
<td>8,750</td>
</tr>
<tr>
<td>Pieter–Paul Gunneweg</td>
<td>2</td>
<td>18</td>
<td>4</td>
<td>24</td>
<td>875</td>
<td>21,000</td>
</tr>
<tr>
<td>Patricia Schwerzel</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>875</td>
<td>875</td>
</tr>
<tr>
<td>Jos Dusseljee</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>875</td>
<td>875</td>
</tr>
</tbody>
</table>

* 5 'mission' days in the Netherlands  

Total: 47 days, fee: $82,250

#### (Inter)national travel/flights**

<table>
<thead>
<tr>
<th>from</th>
<th>to (v.v.)</th>
<th>ticket class</th>
<th>number</th>
<th>price</th>
<th>amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amsterdam</td>
<td>Entebbe</td>
<td>economy</td>
<td>4</td>
<td>1,850</td>
<td>7,400</td>
</tr>
<tr>
<td>Entebbe</td>
<td>Juba</td>
<td>economy</td>
<td>4</td>
<td>470</td>
<td>1,880</td>
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<tr>
<td>Juba</td>
<td>Jonglei State</td>
<td>economy</td>
<td>4</td>
<td>200</td>
<td>800</td>
</tr>
<tr>
<td>Juba</td>
<td>Upper Nile</td>
<td>economy</td>
<td>4</td>
<td>400</td>
<td>1,600</td>
</tr>
</tbody>
</table>

** Based on receipts  

Total: $11,680
### Staying costs

<table>
<thead>
<tr>
<th>Place</th>
<th># of nights</th>
<th>DSA in USD</th>
<th>Total in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entebbe</td>
<td>8</td>
<td>100</td>
<td>800</td>
</tr>
<tr>
<td>Juba</td>
<td>24</td>
<td>100</td>
<td>2,400</td>
</tr>
<tr>
<td>Jonglei State</td>
<td>12</td>
<td>51</td>
<td>612</td>
</tr>
<tr>
<td>Upper Nile</td>
<td>12</td>
<td>51</td>
<td>612</td>
</tr>
</tbody>
</table>

**exch. rate**

|                     | Total | 1.00 | total | 4,424 |

### Travel costs abroad***

| Miscellaneous local travel costs (visa, airport transfers, taxis) | 1,000 |

*** Lump sum

|                     | total | 1,000 |

### Miscellaneous costs***

| Reporting (printing, copying, etc.) | 200 |
| Communication                      | 200 |

*** Lump sum

|                     | total | 400 |

### SUB TOTAL FEES and REIMBURSABLE COSTS in USD

| 99,754 |

| Contingencies****: 3% | 2,683 |
| VAT: 0%               | 0    |

**** Contingencies will only be used when extra costs in the above items have been made and only after your written approval

### GRAND TOTAL in USD

| 102,437 |
1.6 Annexes
CURRICULUM VITAE

1. Name
   Name: Beekes, Albertus Maria Gerardus
   Date and place of birth: 8th August 1956, Heerlen (The Netherlands)
   Nationality: Dutch

2. Present address
   Address: Kastanjelaan 5, 3833 AN Leusden, The Netherlands
   Telephone/Fax: Work: 0031-33-4326030. Mobile: 0031-6-12429721. Fax: 0031-33-4940791
   E-mail address: a.beekes@etcnl.nl

3. Key qualifications / Fields of Expertise
   • Performance based financing
   • Financial management systems
   • Monitoring & evaluation
   • Cost accounting, costing and financing
   • Public/private partnership
   • Human resources / strategic management
   • Management of material resources
   • Training / curriculum development
   • Project management and planning
   • Development of manuals and (computerised) tools for management accounting

4. Summary of work experience
   • Performance Based Financing in Tanzania, Uganda and Ethiopia
   • Evaluation of introduction of flat fees in 6 hospitals in Tanzania
   • Financial Management of the National Health Unit (NHU) and of CBHC programmes in Sudan
   • Progress assessment, tools development and training for managers at different levels in the area of accountability and management of human, financial and material resources of Yambio Hospital, Nzara Hospital and the Diocesan Health Programme in Sudan
   • Development of manuals for financial management, human resources management and diocesan health policy in Sudan
   • Strengthening hospital management in Uganda:
     • Project planning, facilitating series of training for managers and staff of 27 hospitals of the Uganda Catholic Medical Bureau in strategic management, cost analysis and computerised financial management, development of manual for the “management of financial and material resources” and assessment tools, and follow-up implementation of the manual.
   • Financial management improvement project 2005-2008 in Malawi:
     • Development of manual, offering training, follow-up implementation, development of tailor-made computer programme for the management of the payroll and the stores, phase-wise implementation of manual supported with training and progress assessment at hospitals, preparing hospital staff for introduction of computerised accounting and introduction of cost centres.
5. Regional expertise

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>2010–present</td>
<td>Cordaid: Assessment of feasibility and building an implementation model for introducing PBF in health facilities of Emdibir Eparchy, through ECS.</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2009–present</td>
<td>Cordaid: Evaluation of introduction of flat fees in 6 hospitals of the Christian Social Services Commission (CSSC) in Arusha, Bukoba and Kayanga Diocese. Training of hospitals with flat fee on understanding costs and setting fees. Guiding EU project on introduction of Performance Based Financing in Tanzania with CSSC and KCMC.</td>
</tr>
<tr>
<td>North Sudan</td>
<td>2008–present</td>
<td>Sudan Catholic Bishops’ Conference (Khartoum), 2 missions, assist in strengthening financial management of the National Health Unit (NHU) and of CBHC programmes in three Dioceses (Kosti, El Obeid, Juba).</td>
</tr>
<tr>
<td>South Sudan</td>
<td>2006–present</td>
<td>Diocese of Tombura-Yambio (Southern Sudan) / Cordaid: 7 missions to Sudan, assisting the Diocese with progress assessment, tools development and training for managers at different levels in the area of accountability and management of human, financial and material resources of Yambio Hospital, Nzara Hospital and the Diocesan Health Programme. Development of manuals for financial management, human resources management and diocesan health policy.</td>
</tr>
<tr>
<td>Malawi</td>
<td>2005–2008</td>
<td>Christian Health Association of Malawi (CHAM) / Cordaid: 5 missions to Malawi, part of the ‘financial management improvement project 2005-2008’ of the Christian Health Association of Malawi (CHAM), in cooperation with the Government of Malawi, focussed on the 18 CHAM hospitals and their lower level units: development of manual, offering training, follow-up implementation, development of tailor-made computer programme for the management of the payroll and the stores, phase-wise implementation of manual supported with training and progress assessment at hospitals, preparing hospital staff for introduction of computerised accounting and introduction of cost centres.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2009</td>
<td>Cordaid Netherlands; Mid Term Review of EU project on HIV/AIDS (IMPACT) in Bandung.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2008</td>
<td>HealthNet TPO (Kabul/Amsterdam), assisting with setting up information system for costing of BPHS in Nangarhar Province.</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>2005</td>
<td>KNCV Tuberculosis Foundation: chairing a 3-day workshop for staff of the International Department of the KNCV Tuberculosis Foundation, the Netherlands.</td>
</tr>
</tbody>
</table>
6. **Language skills**

Competence on a scale of 1 to 5 (1 - excellent; 5 - basic).

<table>
<thead>
<tr>
<th>Language</th>
<th>Reading</th>
<th>Speaking</th>
<th>Writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch</td>
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<td>1</td>
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<tr>
<td>English</td>
<td>1</td>
<td>1</td>
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<tr>
<td>German</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

7. **Educational record**

2001 - 2003 MSc in Health Systems Management (London School of Hygiene & Tropical Medicine)
1988 - 1991 PhD in Social Sciences (University of Utrecht)
1980 - 1985 BA and MA Degree Sociology (University of Utrecht)
  Specialisation in Theory and Methodology, minors in Cultural Anthropology and Social Psychology
1978 - 1980 Basic training in Human Resources Management (Social Academy De Nijenburgh, Culemborg)

8. **Employment record**

Present Position:
- Senior Consultant - ETC Crystal in Leusden, the Netherlands (since January 2008)
  - Consultant with a special focus on Health Systems Management

Previous Positions:
- Consultant - Public Health Consultants in Amsterdam, the Netherlands (Nov 2004 - Dec 2007)
  - Self-employed consultant, working in association
- Project Coordinator - Uganda Catholic Medical Bureau in Kampala, Uganda (Apr 2003 - Oct 2004)
  - Financial management improvement project for the 27 UCMB hospitals
  - Supervision, training, financial support for 22 Health Units and 2 Hospitals
- Coordinator AIDS/Public Health Programme - St. Francis Hospital in Mutolere, Uganda (April 1995 - March 1999)
  - Planning, training and supervision of health education activities
- Assistant Professor – Utrecht University in Utrecht, the Netherlands (January 1986 – April 1995)
  - Teaching philosophy of science, methodology, researching gender developments on the labour market

9. **Other relevant information**

- Membership of professional bodies:
  Working Group Health and Development (GEO) of the NvTG (Netherlands Society of Tropical Medicine and International Health)
- Skills:
  - MS Access programming
- List of publications upon request
Core Function Expertise

- **International Development Cooperation:** More than 20 years senior management experience in Africa with private and public development programmes both in health and rural development. Core expertise includes: (1) National, Regional & Rural strategic and operational development, planning, implementation and evaluation; (2) Policy design, formulation & promulgation; (3) Programme design, formulation, monitoring and evaluation; (4) Fund management and control; (5) International relations, civil society development, public-private synergies; (6) Governance, public administration, management & reforms; (7) SWAPs, Organisation & Institutional analysis & capacity trajectories; (8) Human resources development, Trainer of Trainers;

- **International Health:** (1) Health system assessment & development; (2) Health planning, implementation, monitoring, evaluation, HMIS; (2) Public health; (3) Health sector reform; (4) Facility management; (4) Public private partnerships & synergies, (5) Trainer-of-Trainers.

Education

2009 – 2010  University of Leiden, Faculty Social Sciences, Leiden, The Netherlands: **Public Administration, International Administration** (MSc)

2008  Royal Tropical Institute (KIT), Amsterdam, The Netherlands: **Health Sector Reform & Financing** (Certificate)


1991 – 1993  University of Amsterdam, Faculty of Political and Social-Cultural Sciences (UvA), Amsterdam, The Netherlands: **Sociology: Organisation & Policy** (MSc)

1989  Open University, Heerlen, The Netherlands: **Management for Non-Profit Organisations** (Certificate)


1983 – 1984  Academy for Higher Education, Leusden, The Netherlands: **Lecturer in Higher Health Education** (Ba)


Employment Record

07 2009 Consultant: Current expertise is on support to strategic development processes, programme design and evaluation, development of capacity development trajectories, training governing bodies (e.g. State level, county level, organisational level) and support to public private partnerships and synergies.

03 2005 – 07 2009 Advisor Public Health DANIDA: Health Sector Programme Support (HSPS) programme, Lake Zone; Mwanza, Shinyanga, Mara and Kagera Regions, Tanzania. Employed by Ministry of Foreign Affairs of Denmark (Danida) as bi-lateral technical expert attached to Policy and Planning Department Ministry of Health and Social Welfare, Tanzania. HSPS, was part of the long-term bi-lateral development assistance of Denmark to the Health Sector of Tanzania. HSPS works within the Sector Wide Approach for Health sector in Tanzania but has specific additional focus areas: (1) Health System Development, (2) Human Resources for Health, capacity development, training Regional & District health management Teams, (3) Regional & District Health Planning, Monitoring and Evaluation, (4) Health Financing, (5) Public-Private-Relationships; (6) HMIS.

06 2002 – 02 2005 Regional Advisor & Coordinator DGIS: District Rural Development Programme (DRDP), Kagera Region, Tanzania. Employed by Ministry of Foreign Affairs of The Netherlands as bi-lateral expert. The DRDP is part of a long-term Regional Development Assistance programme under the bilateral development co-operation between Tanzania and The Netherlands. The programme has a Technical capacity support component (TA) and a Financial Assistance component directed to support social and economic development of 5 districts in Kagera Region. TA component is in support of capacity strengthening of core tasks of Local Governments, improved local governance including involvement and participation of non-government actors (civil society) in governance, development planning and implementation mainly through organisational development (OD) and institutional strengthening (IS) of stakeholders. Moreover the programme is supporting the restructuring process of Local Authorities in the context of a national decentralization process of devolution of administrative, financial and political powers from national Government to Local Government.

01 1998 – 06 2002 Advisor District Development DGIS: Karagwe District Rural Development Program (KDRDP), Karagwe District, Tanzania. Employed by Ministry of Foreign Affairs of The Netherlands as bi-lateral expert. The KDRDP is part of a long-term Regional Development Assistance programme under the bilateral development co-operation between Tanzania and the Netherlands. The KDRDP is institutionally linked with the District Government. Apart from distinct development investments in economic and social sectors, the KDRDP focussed on capacity support LGA, improved local governance and institutional support and collaboration with Non-state actors: civil society and private sector.

Regional Planning & Intervention Advisor DGIS: Drought Monitoring Program (DMP), Turkana, Marsabit, Isiolo and Samburu Districts, Kenya. Funded by Netherlands Development Cooperation. Employed by DHV (Panafcon), Netherlands Consultancy firm. A regional food security project in 4 (semi-)arid districts of Northern Kenya operating a food security information system for nomadic livestock holders and operating drought related disaster management capacity through organisational and institutional development of main stakeholders.

Manager/Co-ordinator SNV: District Health Program, Turkana District, Kenya. A District wide curative and preventive health care program under auspices of the Turkana Rehabilitation Project (TRP) Funded by The Netherlands development Cooperation, EC and WFP. Employed by foundation for Dutch Volunteers (SNV), The Netherlands.

Manager/Trainer Hospital Ward (Internal Medicine): Regional Hospital ‘Het Spaarne Ziekenhuis’, Heemstede/Haarlem, The Netherlands.

Lecturer/Trainer: School of registered nurses/General Hospital, ‘St.Liduina Stichting’, Boxtel, The Netherlands.

Professional Experience in International Development cooperation

Advisor Public Health: Health Sector Programme Support (HSPS) programme, Lake Zone; Mwanza, Shinyanga, Mara and Kagera Regions, Tanzania.
- Advising, Facilitation & Training Ministry of Health at Regional (4) and District level (31) on all aspects of Health System Development, Policy and Planning (e.g. Strategic & annual planning, development district planning tools which were nationally scaled up, design supervision schedules, participation in annual reviews of health sector, etc.), M&E (e.g. introducing integrated health facility based HMIS, quality assurance tools, support to supportive supervision Regional and District levels), HRH (support to establishment of MD training school, establish Nurse Tutor training school), Support to establish health financing systems (Formal and informal, community based).
- Facilitation and development Public-Private Partnerships for improved, more equitable and affordable health care delivery (e.g. Support to umbrella organisation for Church owned health services, support to individual church owned health facilities, established joint public and non-public supervision and performance reviews, development and introduction of service agreement between Public and Non-Public sector.
- Designing and overseeing implementation of innovative capacity support programmes for improved Public Health through public, private and church facilities and projects, e.g. general & financial management of hospital services, clinical services (Adult and neonatal Intensive Care, Post abortion care, diabetes, mental health, preventive screening services for cervix carcinoma, community/ home-based HIV/AIDS, dental care, maternal care, outreach clinical consultant services, epidemic preparedness, etc.)

Regional Advisor & Coordinator: District Rural Development Programme (DRDP), Kagera Region, Tanzania.
Specific responsibilities:
- Advisor to Royal Netherlands Embassy in all matters concerning programme identification, management, appraisal, implementation, M&E and reporting of both programme components: (1) Financial Assistance
and (2) Technical Assistance. Co-responsible for formulation of new 5-year RNE support programme in support of Rural Development and Local Government support in Tanzania.

- Policy and Strategy development towards financial assistance programme and Technical Assistance provision, involving formulation of a comprehensive TA plan and programme.
- Synthesis of programme experiences and publication of various programme lessons: participatory development planning, M&E, base-line studies, etc.
- Public Administration Advisory support to Local and Regional Government authorities in support of capacity strengthening related to the Local Government Reform Programme in particularly: (1) development planning and budgeting, (2) management and administration of resources, (3) promulgation of Local Government Reform Programme in close collaboration with LGRP team in DSM and Zonal reform Team in Mwanza.
- Liaison with National Government departments (PO-RALG) and project units (LGRP), Sector Ministries and technical support institutions (Research programmes, Universities, etc.), bi-lateral and multilateral donors on relevant programme matters, future programme modalities, etc.
- Participate in Development of National local Government M&E System and Planning & Reporting system (PO-RALG/LGRP).
- Programme evaluation and formulation
- Team leader technical assistance staff both long-term and short-term of national and international consultants
- Budget supervisor/holder & financial administration (Annually approximately: EURO 3,000,000/-)

01 1998 – 06 2002 Advisor District Development: Karagwe District Rural Development Program (KDRDP), Karagwe District, Tanzania.

Specific responsibilities:

- Provision of advisory- and facilitative support to all stakeholders in the District both Government and non-Government (churches, parishes, civil society and private sector) in order to improve economic and social development (sector departments, NGOs, CBOs, private entrepreneurs, NGO networks, Chamber of Commerce, special interest groups, etc.)
- Support to institutional and organisational development and institutional collaboration of Local Government and civil society organisations (NGOs, Private Business, Chamber of Commerce and Industries etc.)
- Facilitate and support formulation longer-term development strategies and annual comprehensive district development plans incorporating all economic and social sectors including cross-sector issues such as gender, environment, and HIV/AIDS
- Advisor to Local Government in all matters related to development programme identification & appraisal, participatory planning, implementation, M&E, reporting, financial administration
- Facilitating organisational learning and identifying and structuring organisational changes processes
- Facilitating HR development through capacity needs assessment, formulation of comprehensive capacity support plans, etc.
- Advisor to Local Government in all matters related to public administration and policy and strategy development (e.g. sector policies, maintenance policies, revenue rationalisation policies, etc.), HRM&D
- Supervision Budget and resources (e.g. vehicles etc.) utilisation, administration and reporting
- Initiate and facilitate institutional collaboration between various donor agencies
- ‘On-Hands’ and ‘Off-Hands’ training of individual stakeholders
- Facilitating socio-economic base-line surveys
01 1996 – 12 1997 **Project Manager:** Primary Health Care and AIDS/HIV Program, Soroti District, Uganda.
Specific responsibilities:
- Overall co-ordination of program design, planning and implementation, M%E, Reporting
- Financial management including resource mobilisation
- HRM local and international staff (>250pp)
- Support to local parishes, NGOs, CSOs, community groups, etc.
- Mainstreaming HIV/AIDS programming in district development planning

09 1993 – 10 1995 **Regional Planning & Intervention Advisor:** Drought Monitoring Program (DMP), Turkana, Marsabit, Isiolo and Samburu Districts, Kenya.
Specific responsibilities:
- Project design, planning, implementation
- Design, Management and Analysis of information system including write-up of monthly Districts specific ‘drought monitoring bulletins’
- Planning, co-ordination and M&E of drought mitigation interventions (e.g. re/de-stocking, food-/cash-for-work etc.)
- Capacity support and co-ordination with participating Government Departments, NGOs and Church organisations
- Training of local enumerators
- Financial management and budget control
- Reporting to stakeholders and donors

02 1987 – 05 1991 **Manager/Co-ordinator:** District Health Program, Turkana District, Kenya.
Specific responsibilities:
- Overall formulation, co-ordination and management of program including preparation and handing-over to Ministry of Health
- Member District Health Management Board
- Design and establish a ‘Child Health Information System’
- Resource mobilisation for infra-structural investments
- M&E, Reporting, Financial control
- HRM all local and International staff (>30pp)
- Establishment sponsorship fund for local (para-) medical staff

**Consultancies:**

1997 06 Formulation of long-term AIDS/HIV prevention and control programme for Soroti and Katakwi districts, North Uganda, commissioned by ICCO, The Netherlands (team leader)
1997 03 Formulation of District Health Support Program for Kotido and Moroto Districts, Uganda, commissioned by DANIDA (team leader)

**Publications:**

2004 CWIQ Baseline Study on Welfare and Service Delivery for Kagera Region, Tanzania; CWIQ is an off the shelf survey from World bank for establishing levels of poverty and welfare for rural communities (Co-author).
1999 ‘Habari ya Kazi’ (‘How are you doing’) a Practical Guide for Project Planning, Monitoring and Evaluation’; A practical guide with tools and instruments for local communities to assist in planning for development.
Languages:

Dutch: Mother Tongue
English: Fluent
Kiswahili: Fluent
French: Basic
German: Basic

-END-
CURRICULUM VITAE

1. Family name: Liem
2. First name: Loan
3. Date of birth: 04 October 1961
4. Nationality: Dutch
5. Civil status: Married
6. Address: ETC Crystal, P.O. Box 64, 3830 AB LEUSDEN, the Netherlands
   Telephone number: +31 - (0)33-4326030 (office)
   E-mail: crystal@etcnl.nl (office)
7. Education:
   Institution: Liverpool Institute of Tropical Medicine, United Kingdom
   Date: 1999
   Degree(s) or Diploma(s): Masters in Public Health (Distinction)
   Institution: Liverpool Institute of Tropical Medicine, United Kingdom
   Date: 1994
   Degree(s) or Diploma(s): Certificate course: Primary Health Care Management
   Institution: Royal Tropical Institute, Amsterdam, the Netherlands
   Date: 1990
   Degree(s) or Diploma(s): Certificate course: Tropical course for Medical Doctors
   Institution: Radboud University Nijmegen, the Netherlands
   Date: 1980 – 1988
   Degree(s) or Diploma(s): Medical Doctor
8. Languages:
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<tr>
<td>German</td>
<td>2</td>
<td>2</td>
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</tbody>
</table>
   *score 1 – 5; 1= not aware, 2= poor, 3=moderate, 4= good, 5= excellent
9. Membership of professional bodies:
   Currently: Member of the Association for Tropical Medicine and International Health, the Netherlands
   Previously: Member of the Quality Group of the Netherlands Collaborative Inter-Agency Foundation
   Member of monitoring committee of the research project “Equator”, mental health for refugees in the Netherlands, University of Amsterdam
   NGO representative for the National Quality Working Group, Ministry of Health, Cambodia
   Selected NGO member of the Gender Regional Dimension Project from UNFPA, Asia
   Selected NGO member of the National HMIS working group, Afghanistan
   Member of the National Diocesan Cost-Recovery Initiative, Moshi, Tanzania
10. Present position: Consultant with ETC Crystal, the Netherlands. Public Health Specialist
11. Years of professional experience:
   Years of service in current position:

12. Key qualifications:
   - Medical background with experience in health systems development, focussing on reproductive health, monitoring and evaluation and research
   - Experienced in the humanitarian health interventions, design of complex emergency programmes and supporting health programmes in post-conflict and fragile states
   - Experienced in programming for refugees and internally displaced people
   - Specific interest in participatory approaches, capacity building of local NGOs, community participation and downward accountability

13. Other skills:
   Analytical skills, training in project planning, M&E, developing innovative approaches

14. Employment record:

<table>
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<tr>
<th>Date</th>
<th>2009 onwards</th>
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<tbody>
<tr>
<td>Location</td>
<td>Leusden, the Netherlands</td>
</tr>
<tr>
<td>Company</td>
<td>ETC Crystal</td>
</tr>
<tr>
<td>Position</td>
<td>Consultant</td>
</tr>
<tr>
<td>Description</td>
<td>Consultancies, see below</td>
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<table>
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<tr>
<th>Date</th>
<th>2005 – 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>The Hague, the Netherlands</td>
</tr>
<tr>
<td>Company</td>
<td>Dutch Refugee Foundation (Stichting Vluchteling)</td>
</tr>
<tr>
<td>Position</td>
<td>Senior programme manager, including health portfolio</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>2002-2005</th>
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<tr>
<td>Location</td>
<td>Amsterdam, the Netherlands</td>
</tr>
<tr>
<td>Company</td>
<td>Medicines sans Frontiers</td>
</tr>
<tr>
<td>Position</td>
<td>Health Advisor</td>
</tr>
<tr>
<td>Description</td>
<td>Advising medical and humanitarian programmes in Asia (Nepal, Myanmar, Bangladesh, India) and Africa (DRC) e.g. on proposal development, identifying strategies, implementation, M&amp;E and operational research on malaria treatment. Designing and conducting training in planning, monitoring and evaluation. Portfolio holder of community participation in health programmes. Advising on setting up HIV/AIDS programmes with the innovative component of providing ARV’s in a conflict setting.</td>
</tr>
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</table>

<table>
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<tr>
<th>Date</th>
<th>2000-2002</th>
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</thead>
<tbody>
<tr>
<td>Location</td>
<td>Kampot/Phnom Penh, Cambodia</td>
</tr>
<tr>
<td>Company</td>
<td>Cordaid</td>
</tr>
<tr>
<td>Position</td>
<td>Youth Reproductive Health Project Coordinator - till 2001 part-time 50%, combined with position as PHC/MCH Manager (50%)</td>
</tr>
<tr>
<td>Description</td>
<td>Responsible for capacity building of the local NGO partner, advising on project management and implementation. Conducted internal evaluation. This project was a component of the Regional Reproductive Health Initiative of UNFPA/EC.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Location</td>
<td>Kampot, Cambodia</td>
</tr>
<tr>
<td>Company</td>
<td>Cordaid</td>
</tr>
<tr>
<td>Position</td>
<td>PHC/MCH manager (part-time 50%)</td>
</tr>
<tr>
<td>Description</td>
<td>Responsible for managing a health team and supporting and building the capacity of the Provincial and District Health authorities to implement the Master Health plan. Advising policymakers and developing monitoring tools. Coordinating quantitative and qualitative research.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Date</th>
<th>1996-1998</th>
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<tbody>
<tr>
<td>Location</td>
<td>Peshawar, Pakistan</td>
</tr>
<tr>
<td>Company</td>
<td>Memisa Holland – IbnSina Afghanistan</td>
</tr>
<tr>
<td>Position</td>
<td>Technical Director</td>
</tr>
<tr>
<td>Description</td>
<td>Responsible for managing and integrating MCH/PHC and EPI Programmes in 5 Provinces in Afghanistan through the local NGO IbnSina. Capacity building, proposal writing, budgeting, report writing and fund raising. Advising the National Steering Committee Afghanistan on health policies and strategies.</td>
</tr>
</tbody>
</table>
Date: 1995-1996  
Location: Peshawar, Pakistan  
Company: Memisa Holland – AVICEN France  
Position: Technical Manager  
Description: Responsible for start-up and running of an EC funded MCH/PHC/EPI programme in 7 Provinces in Afghanistan, as well as in four refugee camps in Pakistan. Coordinating and implementing training of (master) trainers in EPI, MCH and PHC at national level. Founding member of the local NGO IbnSina that was created at the end of this period.

Date: 1992-1994  
Location: Moshi, Tanzania  
Company: Memisa – Moshi Diocese  
Position: Diocesan Medical Officer  
Description: Responsible for initiating and supervising a comprehensive PHC programme for 31 Diocesan Health Centres including setting up a Diocesan Medical Store. Designing and Implementing training programmes in CBHC. Researching possibilities for a future cost-recovery system at national level.

Date: 1991-1992  
Location: Kibosho, Tanzania  
Company: Memisa – Moshi Diocese  
Position: Medical Officer, Kibosho Designated Districts Hospital  
Description: Responsible for providing Comprehensive Curative and Preventive services at a 180 bedded Referral Hospital. Supervision of 14 health centres.

Date: 1988-1990  
Location: Den Helder and Geleen, the Netherlands  
Company: Gemini and Barbara Hospital  
Position: Medical Officer Surgery/Orthopaedics respectively Gynaecology and Obstetrics

15. Selection of consultancy records:

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Company; description of mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania-Uganda</td>
<td>2010</td>
<td>Home Based Care scan related to PLWHA, OVC, elderly and disabled people for Cordaid</td>
</tr>
<tr>
<td>Haiti</td>
<td>2010</td>
<td>Start-up Manager of Cordaid Haiti post-earthquake health programmes in PHC, mental health, surgical interventions and rehabilitation</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>2010</td>
<td>Lecturer, including review of community participation and accountability module for the Masters in Public Health, Dutch Royal Tropical Institute (KIT). Thesis support for Master students</td>
</tr>
<tr>
<td>DRC- Burundi</td>
<td>2009-2010</td>
<td>Backstopping Community Driven Reconstruction Programme Stichting Vluchteling / International Rescue Committee and facilitation of Mid-Term Review</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2009</td>
<td>Technical support and initiating Cordaid’s Emergency health Intervention for IDPs in NWFP</td>
</tr>
<tr>
<td>Global, Liberia</td>
<td>2009</td>
<td>Review of Merlin’s 2nd health care policy and implementation for Merlin-UK</td>
</tr>
<tr>
<td>Sri Lanka, UK</td>
<td>2006</td>
<td>Organizational evaluation of International Medical Corps for Dutch Refugee Foundation and evaluation IMC’s primary health care and mental health projects in Sri Lanka post-Tsunami</td>
</tr>
<tr>
<td>DRC, India, Bangladesh, Myanmar, Nepal</td>
<td>2002-2005</td>
<td>Technical support to a wide range of humanitarian and post-conflict interventions for MSF-Holland including regular visits. Support consisted of: Input in country strategies, reviewing proposals, monitoring implementation, designing research project and advocating for ACT malaria treatment at national level. Involvement in the Introduction of ARV in (post-)conflict context as one of the pilot HIV/AIDS projects.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2002</td>
<td>Assessment of Reproductive Health needs in Afghanistan for the Dutch Royal Tropical Institute (KIT) / German Foundation for International Development (DSE)</td>
</tr>
<tr>
<td>Cambodia</td>
<td>2002</td>
<td>Organising the national seminar of the EC/UNFPA Youth Reproductive Health Programme in Cambodia for UNFPA/Cordaid at the end of their programme</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1998</td>
<td>Designing and preparing the evaluation mission for Cordaid. The evaluation reviewed all programmes of the Afghan Health Organisation IbnSina. Strategies and instruments were developed to include females during the evaluation.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1997</td>
<td>Evaluation of PHC services, including hospital services targeting underserved Christian population in Lahore province for Memisa Medicus Mundi</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1994</td>
<td>Evaluation of the HIV/AIDS Programme for the Diocese of Moshi</td>
</tr>
</tbody>
</table>

16. List of publications available on request
CURRICULUM VITAE

1. Family name: Dusseljee
2. First name: Jos (J.H.J.)
3. Date of birth: 4th January 1958
4. Nationality: Dutch
5. Civil status: Married
6. Address: ETC Crystal, P.O. Box 64, 3830 AB LEUSDEN, The Netherlands
            31(0)33-4326030 (office)
            e-mail: crystal@etcnl.nl (office) j.dusseljee@etcnl.nl (personal)

7. Education:
   Institution: University of Groningen, the Netherlands
   Date: 1982
   Degree(s) or Diploma(s) Masters in Business Administration; specialisation in management of health care institutions

   Institution: University of Nijmegen, the Netherlands
   Date: 1993
   Degree(s) or Diploma(s) Certificate Primary Health Care Tools Course

   Institution: Management for Development Foundation, Ede, the Netherlands
   Degree(s) or Diploma(s) courses in project cycle management, monitoring, organisational analysis, communication, private sector development

8. Languages:

<table>
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<tr>
<td>Kiswahili</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

   *score 1–5; 1= not aware, 2= poor, 3=moderate, 4= good, 5= excellent

9. Membership of professional bodies:
   Currently:
   • Treasurer of the foundation Doctors to Developing Countries
   • Board member of WEMOS (advocacy organisation in international health)
   • Board member of Josephine Nefkens Foundation (supporting health programmes in Africa)
   • member of the Technical Review Panel of the Global Fund to fight HIV/AIDS, Malaria and Tuberculosis
   • Member of the Dutch Health Insurance Platform steering committee

   Previously:
   • Chair of ETC Company Council
   • Chair of Share-Net (Netherlands Network on Sexual & Reproductive Health and AIDS);
   • Treasurer of the Netherlands Society of Tropical Medicine
   • Treasurer of the Foundation Tropical Geographical Medicine
### 10. Present Position:

**Specific activities:**
- Management of the unit (10 consultants, 2 support staff, large number of associate consultants)
- Development of technical capacity within ETC Crystal on private sector involvement in health system development, with specific interest in alternative contracting and financing arrangements
- Technical support to health systems strengthening in both fragile and stable countries
- Providing short consultancy (programme identification, formulation, evaluation, M&E)

### 11. Years of professional experience:
**More than 25 years**

**Years of service in current position:**
6 years

### 12. Key qualifications:
- Consultation on various aspects of health systems development, both in post-conflict and 'stable' contexts and countries, with a specific focus on and interest in private sector involvement and public private partnership in health.
- Consultation on health financing (incl. systems of user charges, performance based financing, equity funds and health insurance
- Consultation on institutional and strategic development
- Consultation on mainstreaming HIV/AIDS and sexual & reproductive health
- Good social, diplomatic, analytical, negotiating and writing skills

### 13. Other Skills
- Teaching (health financing; public private partnerships) at a variety of training venues (KIT, MDF, Erasmus University Rotterdam, etc.)
- Facilitating workshops and trainings

### 14. Employment record:

**Date:** 2004 onwards  
**Location:** Leusden, the Netherlands  
**Company:** ETC Crystal  
**Position:** Senior consultant; unit manager (since April 2008)  
**Description:** Health systems development in general, public private partnership with emphasis on NGO and private sector involvement in health care in particular

**Date:** 2001-2003  
**Location:** Amsterdam, the Netherlands  
**Company:** HealthNet International  
**Position:** Operational Director  
**Description:** Daily management of operational department (3 assistants, two advisors) and around 25 expatriate field staff responsible for health care rehabilitation programmes in 10 different post-conflict countries. A number of programmes were embedded in health reforms and involved the introduction of performance based contracting arrangements complemented by equity funds

**Date:** 2000-2001  
**Location:** The Hague, the Netherlands  
**Company:** Cordaid  
**Position:** Health and HIV/AIDS Coordinator  
**Description:** Coordination and policy development of health care and HIV/AIDS related interventions in a multi-sectoral development organisation.

**Date:** 1990-1999  
**Location:** Rotterdam, the Netherlands  
**Company:** Memisa Medicus Mundi  
**Position:** Programme Officer East Africa (90-'96); Team Leader Asia department; Head Asia and East Africa department; Head Asia and West Africa department (96-'99)  
**Description:** Responsible for financial and personnel assistance to health programmes and health institutions in developing countries including humanitarian assistance and health system rehabilitation; involved in all issues of project cycle management; provided technical leadership to a number of major institutional reforms of hospitals, which included change of ownership, rearrangement of services and introduction of innovative (self) financing mechanisms

**Date:** 1986-1990  
**Location:** Kakamega, Kenya  
**Company:** Diocese of Kakamega / Memisa Medicus Mundi  
**Position:** Administrative consultant
Description: Providing consultative services on general, financial, operational and strategic management and human resources development to 4 hospitals and 8 health centres and primary health programmes; seeking to match adequate quality services, financial sustainability and equitable access to the poor.

Date: 1982-1986
Location: Assen, Emmen, the Netherlands
Company: Wilhelmina Hospital, Shepard Hospital
Position: Internal organisational advisor

Description: Providing consultative services on a wide range of internal organisational problems and challenges

15. Selection of consultancy records (out of total of some 50 consultancies since January 2004):

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Description of mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>2010</td>
<td>Cordaid, provision of technical assistance to piloting performance based financing in home based care</td>
</tr>
<tr>
<td>DR Congo</td>
<td>2010</td>
<td>Dutch Refugee association: evaluation of IMC health care rehabilitation program, South Kivu</td>
</tr>
<tr>
<td>Lesotho</td>
<td>2010</td>
<td>World Bank, conducting a feasibility study on Performance Based Financing at primary health care level</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2009</td>
<td>Providing support to fund applications of two Dutch agencies, including an analysis of the institutional, organisational and financial capacity of these agencies and their core partners</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2009</td>
<td>Participation in the technical review of GFATM Round 9 applications for funding</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2009</td>
<td>ETC, facilitating the development of a long term strategy plan for the organisation, the various units that make up ETC and associated international networks</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2009</td>
<td>Cordaid, facilitating the development of a long term strategy plan for the health and social welfare department</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2009</td>
<td>MCNV (Medical Committee Netherlands Vietnam); facilitation of development of long term strategy plan</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>2009</td>
<td>BOOM (working group of Dutch organisations active in Bangladesh); Follow-up on mission in 2009,</td>
</tr>
<tr>
<td>Sudan</td>
<td>2009</td>
<td>Cordaid/HealthNet TPO; conducting a feasibility study on possibility of handing-over of a health sector rehabilitation programme in Aweil State in Southern Sudan, with emphasis on options for alternative performance based financing models and development of county health departments</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>2008</td>
<td>BOOM (working group of Dutch organisations active in Bangladesh); development of framework for strengthening and formalizing cooperation between counterpart NGOs, the Netherlands Embassy and the MoHFW, focusing on SRHR</td>
</tr>
<tr>
<td>Zambia</td>
<td>2008</td>
<td>Cordaid; technical assistance to a re-strategising process of the Integrated Aids Programme of Ndola Diocese.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2008</td>
<td>HealthNet TPO: progress assessment of hospital management reforms in the Jalalabad Public Health Hospital</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2008</td>
<td>Cordaid: evaluation of Mother and Child Health Programme and Hospital Financing programme in catholic health institutions</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2008</td>
<td>Oxfam Novib: evaluation of Shuhada and IbnSina BPHS programmes in Bamyan Province</td>
</tr>
<tr>
<td>UK, Liberia and Palestinian Territories</td>
<td>2007</td>
<td>Merlin: review of best practices in respect to MoH-NGO collaboration (including policy development, institutional strengthening, contracting service provision) in countries in transition</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2007</td>
<td>Cordaid: Exploratory study to determine most effective contributions by faith based organisations to health system development and HIV/AIDS control in Papua Province</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2007</td>
<td>Oxfam Novib: Evaluation of the BRAC (Bangladesh Rural Advancement Committee) health programme in two provinces in Afghanistan</td>
</tr>
<tr>
<td>USA</td>
<td>2007</td>
<td>Dutch Refugee foundation: exploratory mission to assess the potential for a formalized partnership with IRC, a large US-based humanitarian agency.</td>
</tr>
<tr>
<td>Zambia</td>
<td>2007</td>
<td>Integrated AID Programme, Diocese of N'dola: conducting a mid-term review</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2007</td>
<td>IOB (bureau within Ministry of Foreign Affairs) which evaluates development aid programmes in the Netherlands); policy evaluation of sexual and reproductive health programmes of international NGOs that are funded by the Dutch Ministry of Foreign Affairs.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2007</td>
<td>Evaluation of tsunami programmes funded by the Dutch Refugee Foundation, and implemented by IRC and Cardi in Aceh, Indonesia</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2007</td>
<td>Cordaid, end-term-evaluation IbnSina primary health programme in Laghman Province</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2007</td>
<td>HealthNet TPO: formulation of a provincial health sector plan for Nangarhar Province in</td>
</tr>
<tr>
<td>Location</td>
<td>Year</td>
<td>Project Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kenya</td>
<td>2006</td>
<td>Response to an EC tender for contracting-in health services</td>
</tr>
<tr>
<td>Netherlands, South Africa, Zambia</td>
<td>2006</td>
<td>Co-facilitating the establishment of a consortium of humanitarian agencies to access MDTF funding in two states in Southern Sudan</td>
</tr>
<tr>
<td>UK, Croatia, Pakistan, Indonesia</td>
<td>2006</td>
<td>Evaluation of the HIV/AIDS workplace policy of the Royal Netherlands Embassies</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2006</td>
<td>Dutch Refugee Foundation: Institutional and programmatic evaluation of IMC</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2006</td>
<td>HN-TPO: End term evaluation of an EC funded malaria and leishmaniasis control programme</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2006</td>
<td>GNP+ (Global Network for People Living with AIDS); facilitation of strategy formulation process</td>
</tr>
<tr>
<td>Netherlands/Kenya</td>
<td>2005</td>
<td>Ministry of Foreign Affairs the Netherlands: development of a policy paper on health financing in general and health insurance in particular, with emphasis on private sector involvement</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2005</td>
<td>DANIDA, Ministry of Health Tanzania: Health Sector Review 2005: study into options for promoting public private Partnership for equitable provision of quality health services.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2005</td>
<td>Health Action International (international advocacy network): Design of and support to self-evaluation process</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2004</td>
<td>Development of the course ‘Private Sector Contribution to Development. Strengthening private sector contributions to pro-poor economic growth’; in co-operation with MDF (the Netherlands)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2004</td>
<td>Cordaid: contributing to a policy document on effective HRM and HRD strategies</td>
</tr>
<tr>
<td>Zambia</td>
<td>2004</td>
<td>Cordaid: formulation of funding proposal for community based ARV programme</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2004</td>
<td>IDA: formulation of capability statement</td>
</tr>
<tr>
<td>Uganda</td>
<td>2004</td>
<td>Cordaid: facilitation of Conference of church leaders on church involvement in health care</td>
</tr>
<tr>
<td>South Africa, Nigeria, Kenya</td>
<td>1986-</td>
<td>More than 10 consultancies on a wide range of operational, personnel, general and financial management issues of health care institutions and diocesan health care programmes were conducted on behalf of a variety of funding agencies and church-related health care institutions.</td>
</tr>
</tbody>
</table>

Asia (Afghanistan, Bangladesh, Cambodia, India, Iraq, Pakistan, Papua New Guinea, Philippines, Thailand, Vietnam)

Africa (DRC, Kenya, Malawi, Rwanda, South Africa, Tanzania)
Uganda, Zambia, Zimbabwe.

**Eastern Europe**
(Kosovo, Bosnia Herzegovina)
CURRICULUM VITAE

1. Family name: Schwerzel
2. First name: Patricia C.C.
3. Date of birth: 3 September 1960
4. Nationality: Dutch
5. Civil status: Married
6. Address: ETC Crystal, P.O. Box 64, NL-3830 AB LEUSDEN, The Netherlands, p.schwerzel@etcnl.nl and www.etc-crystal.org

7. Education:
   Institution: Business School Nederland, (NVAO, DVC accredited), Buren, the Netherlands
   Date: In progress since 14th April 2009.
   Degree(s) or Diploma(s): Two year MBA study in progress.
   Phase 2 in progress (Organisational Analysis phase, Theoretical study and Action Learning Projects).

   Institution: University of Amsterdam, The Netherlands
   Date: 09/1990- 05/1995
   Degree(s) or Diploma(s): MSc Medical and Welfare Sociology (Health System Development, Social security systems, Health insurance systems, Health Finance systems, Legal systems) with specialisation in Medical Anthropology and HIV and AIDS.

   Institution: Royal Tropical Institute, Department of Tropical Hygiene, Amsterdam, The Netherlands
   Date: 02-03-1987
   Degree(s) or Diploma(s): Course Health Care in the Tropics

   Institution: Institute for Higher Education in Health Care, Leusden, The Netherlands
   Date: 09/1984- 05/1986
   Degree(s) or Diploma(s): BA in Public Health

   Institution: Regional Hospital Groot Zieken Gasthuis, ’s-Hertogenbosch, The Netherlands
   Date: 11/1978- 05/1983
   Degree(s) or Diploma(s): Training for Registered Nurse

7a. Recent meetings, courses and conferences
   7th-14th March 2009 • International Meeting of Sudan Working Group (SWG) for Caritas, CIDSE and Catholic Church partners. Key facilitator during a 5-day meeting in Juba (Sudan). Focus on policy developments, sectoral programme development, strategic alliances and modalities for collaboration between International and Sudanese partners.

   16th-17th December 2008 • ETC Crystal 2 day retreat: Strategic planning, Acquisition strategies, relevant Policy Developments, MFS2 update Capacity Development options.

   24-28th May 2007 • 5th European Congress on Tropical Medicine and International Health: Partnership and Innovation in Global Health, the Netherlands.
   • Organising the Centenary Parallel Session for the Working Group in Tanzania.
   • Keynote Speaker: Human Resources for Health issues affecting public-private partnership in Tanzania.

   28th April 2007 • 4th Annual Meeting of the NVTG Working Group (Dutch Society for Tropical Medicine and International Health) for all Dutch health professionals working in Tanzania, Dar es Salaam.
   • Organising, co-facilitating and presentation on a HRH study regarding the development of a motivation package for health workers in VA hospitals in remote areas of Tanzania.

8. Languages:

<table>
<thead>
<tr>
<th>Language</th>
<th>Reading</th>
<th>Speaking</th>
<th>Writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>English</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>French</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Ki-Swahili</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

*Score 1–5; 1= not aware, 2= poor, 3=moderate, 4= good, 5= excellent
9. Membership of professional bodies:  
- NVTG: Nederlandse Vereniging voor Tropische Geneeskunde en Internationale Gezondheidszorg (Dutch Society for Tropical Medicine and International Health).  
- Member of Editorial Board for *MT: Bulletin of the Netherlands Society of Tropical Medicine and International Health* for the NVTG Work Group Tanzania.

10. Present Position:  
(Since Jan 2003)  
Senior Consultant with ETC Crystal ([www.etc-crystal.org](http://www.etc-crystal.org)), based in the Netherlands  
Activities:  
- Short-term consultancy in Health programme development, health system support, NGO and FBO transition processes, organisational capacity building, user fee systems, quality assurance, health management information systems (HMIS), HIV/AIDS prevention, control and mainstreaming and pastoralist health  
- Long-term health technical and management support to development partners (for 3-5 year periods).  
- Trainer and Master Thesis external examiner (MPH/MIH) for Royal Tropical Institute (KIT), Amsterdam, The Netherlands  
- Facilitation of meetings and workshops for development organisations  
- Capacity building in consultancy skills and coaching junior consultants  
- Acquisition and preparation of tender documents

11. Years of professional experience:  
Years of service current position:  
22 years  
11 years of which 5 years with ETC-East Africa (regional office Nairobi) and 6 years with ETC Crystal. Over 100 assignments carried out for ETC. Facilitator in 100 workshops/meetings. Speaker on various conferences.

12. Key qualifications:  
- Team leader in >60 missions of professional teams with national and international consultants.  
- Project Director for Nuffic HRH support programme in Tanzania.  
- Technical Assistance in public-private collaboration in line with the most recent policy framework (Health Sector Reforms, National policies, Decentralisation of health services).  
- Sustainable Institutional and NGO development (strategic planning, project cycle management systems, financial management, policy development, registration processes, legal and tax aspects).  
- Technical Assistance in conflict and post-conflict areas (Linking Relief, Rehabilitation and Development/LRRD).  
- Comprehensive Health Planning, long-term Strategic Frameworks and Budget Plans.  
- Christian Health Associations and Institutional Development.  
- Health Information Management Systems (HMIS).  
- HIV/AIDS/STD Prevention, Control, Mainstreaming and PMTCT/ARV interventions.  
- Primary Health Care/CBHC/Community Development.  
- Pastoralist Health, Food Security and Drought Cycle management interventions.

13. Other Skills:  
- Resource mobilisation for FBOs and NGOs.  
- Mediation/trouble shooting skills.  
- Facilitation techniques.  
- Presentations at conferences and workshops.

14. Employment record:  
Date: 09/2009-present  
Location: Netherlands  
Company: ETC-Crystal Leusden, The Netherlands  
Position: Senior Health Consultant  
Description: See present position, key qualifications and other skills
<table>
<thead>
<tr>
<th>Date</th>
<th>01/2003-09/2009 (6,5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Tanzania</td>
</tr>
<tr>
<td>Company</td>
<td>ETC-Crystal, Leusden, The Netherlands</td>
</tr>
<tr>
<td>Position</td>
<td>Senior Health Consultant associated with ETC Crystal</td>
</tr>
<tr>
<td>Description</td>
<td>See present position, key qualifications and other skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>02/1998-12/2002 (5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Tanzania</td>
</tr>
<tr>
<td>Company</td>
<td>ETC-East Africa, Nairobi, Kenya</td>
</tr>
<tr>
<td>Position</td>
<td>Health Consultant associated with ETC-East Africa</td>
</tr>
<tr>
<td>Description</td>
<td>Short-term consultancy in public health, health programme development, cost recovery and exemption approaches, organisational capacity building, NGO transition processes, health management information systems (HMIS), HIV/AIDS prevention and control, pastoralist health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>01/1996-12/1997 (2 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Uganda (Soroti, Katakwi, Kumi District)</td>
</tr>
<tr>
<td>Company</td>
<td>HealthNet International (HNI)</td>
</tr>
<tr>
<td>Position</td>
<td>Programme Coordinator HIV/AIDS prevention and control programme</td>
</tr>
<tr>
<td>Description</td>
<td>Coordination of HIV/AIDS/STD interventions in three post conflict districts including: programme cycle management, research, participation in national STI programme, transition from international NGO to Ugandan NGO, design and implementation of community based IEC interventions, youth programme, STD prevention, condom promotion, care and counselling, home based care,</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>05/1995 – 10/1995 (6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Kenya (Samburu, Turkana, Marasabit and Isiolo District)</td>
</tr>
<tr>
<td>Company</td>
<td>Drought Monitoring Project (DMP)</td>
</tr>
<tr>
<td>Position</td>
<td>Research Assistant</td>
</tr>
<tr>
<td>Description</td>
<td>Data collection and analysis on drought monitoring, food security, health status and Early Warning System</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>01/1987-09/1990 (almost 4 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Kenya (Turkana District)</td>
</tr>
<tr>
<td>Company</td>
<td>SNV, Netherlands Development Organisation</td>
</tr>
<tr>
<td>Position</td>
<td>Health Coordinator of an integrated Health and Nutrition Programme</td>
</tr>
<tr>
<td>Description</td>
<td>Coordination of District wide PHC programme for pastoralist groups including; programme cycle management, financial management, human resource development, pharmaceutical management, quality of care, supervision rural health facilities, mobile clinics (MCH, EPI, ANC, Growth Monitoring), nutrition programme, CBHC programme, HIV/AIDS training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>09/1984-02/1987 (2,5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>The Netherlands</td>
</tr>
<tr>
<td>Company</td>
<td>Stichting Amsterdamse Kruisvereniging, Amsterdam</td>
</tr>
<tr>
<td>Position</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>Description</td>
<td>Providing public health services in Amsterdam (home based care)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>06/1983-09/1984 (1 year and 3 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>The Netherlands</td>
</tr>
<tr>
<td>Company</td>
<td>Regional Hospital 's-Hertogenbosch</td>
</tr>
<tr>
<td>Position</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Description</td>
<td>Providing nursing care on ward for internal medicine, training of junior nursing students</td>
</tr>
</tbody>
</table>
## 15. Consultancy record:

<table>
<thead>
<tr>
<th>Year</th>
<th>Description of mission / client</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Nuffic/NICHE/TZA 001: Third mission to Tanzania to prepare the inception report and budget with all the regional partners. Organising the Launch of the Project and recruitment of the Project Manager.</td>
</tr>
<tr>
<td>2010</td>
<td>Nuffic/NICHE/TZA 001: Second mission to Tanzania to prepare the inception phase. Meeting with regional partners and preparation for Project Advisory Committee.</td>
</tr>
<tr>
<td>2010</td>
<td>Nuffic/NICHE/TZA 001: First mission to Tanzania to start up the programme and to prepare for the inception phase (Focus on understanding of programme, planning, financial rules and regulation, institutional arrangements).</td>
</tr>
<tr>
<td>2009</td>
<td>For SolidarMed (Switzerland/Ifakara): Development of a 3-year HRH proposal for 3 Nurse Training Schools and 1 Nurse Tutor training school.</td>
</tr>
<tr>
<td>2009</td>
<td>For Cordaid/CSSC: Development Partner Group Meeting and launch of CSSC HRH proposal to development a Grant Management Unit and to support 37 Health Training Institutes. Key presenter.</td>
</tr>
<tr>
<td>2009</td>
<td>For Cordaid/CSSC: Development of a Grant Management system and proposal for the Christian Social Services Commission (CSSC) to provide long term support to the Christian Health Training Institutes in Tanzania with the purpose to scale up the number of trained health workers substantially. Team leader.</td>
</tr>
<tr>
<td>2009</td>
<td>MDF-ESA/Plan Tanzania: Additional data collection and preparation of the Final Mid Term Review report for Plan Tanzania for the Community Health Promotion Program 2005-2010. A trouble shooting mission for MDF-ESA as the first report (from another consultant) was not up to the required standard. Back stopper/Final editor.</td>
</tr>
<tr>
<td>2008</td>
<td>MDF-ESA/Plan Tanzania: Additional data collection and preparation of the Final Draft Mid Term Review report for Plan Tanzania for the Community Health Promotion Program 2005-2010. A trouble shooting mission for MDF-ESA as the first report from another consultant was not up to the required standard. Team leader.</td>
</tr>
<tr>
<td>2007</td>
<td>ICCO and CHAS: (1) Presentations during the African Christian Health Association Bi-annual Conference and (2) assistance to development tender document for Multi Donor Trust Fund (MDTF) Sudan.</td>
</tr>
<tr>
<td>2005</td>
<td>Resource person in 2-day HIV/AIDS meeting between Tanzanian NGOs and Dutch co-funding organisations in Mwanza, Tanzania.</td>
</tr>
<tr>
<td>2005</td>
<td>For TANESA/DGIS: Technical support to TANESA (Tanzania Essential Strategies Against AIDS) for the development of a five-year Strategic Plan (2006-2011). Focus is on re-strategizing TANESA in context of (1) National developments, (2) Mid-Term Review findings, (3) Regional Facilitating Agency function and (4) required transformation from public project in NACP to private NGO status. Backstopping for internal proposal guidelines Royal Netherlands Embassy. Team member.</td>
</tr>
<tr>
<td>2003</td>
<td>For Simavi: Evaluation of a block grant for health projects (PHC, water and sanitation) and assessment of cooperation between Simavi and partner organisation EOTF. Main consultant.</td>
</tr>
</tbody>
</table>
2002 For World Vision USA: Participatory evaluation of HIV/AIDS programme in Kagera Region. Team member (6 team members).
2001 For DanChurch Aid: Evaluation of Kagera Zonal AIDS Control Program (KZACP) in Mwanza, Shinyanga and Kagera Region. Team member.
2000 For Cordaid: CORDAID Field Meeting Dar es Salaam for technical medical field staff working in Tanzania. Preparation and facilitation of Field Meeting. Lead facilitator.
1999 For Misericordia: NGO Organisational Assessment in three districts. Community Based Habitat Environmental Management (CHEMA) in Rulenge Diocese. Team leader (4 team members).
1999 For DGIS: Formulation of a District Health Profile. Bukombe District Development Programme. Team Leader (6 team members).

<table>
<thead>
<tr>
<th>Year</th>
<th>Description of Mission / Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Cordaid: Sudan Bishop Catholic Conference/National Health Unit: Backstopping to NHU team with Linking and Learning programme (proposal preparation), M&amp;E annual report 2009 and TO for strategic planning 2012-2013.</td>
</tr>
<tr>
<td>2009</td>
<td>Cordaid: Diocese of Tombura-Yambio: Facilitation and Preparation of (1) Diocesan Health Policy, (2) Strategic Health Plan 2010-2013 and BSF Proposal for 18 months. Lead consultant</td>
</tr>
<tr>
<td>2009</td>
<td>Cordaid: Facilitation of 3-day Cordaid Partner Consultation meeting in Sudan (Juba) with a focus on strategy development and improved collaboration, linking and learning. Lead consultant</td>
</tr>
<tr>
<td>2008</td>
<td>WB/IMA/CHAS/ETC Crystal/TICH Consortium: Consortium meeting for Upper Nile and Jonglei State, Nairobi</td>
</tr>
<tr>
<td>2007</td>
<td>Cordaid: 1st mission: Development of a Monitoring and Evaluation system for the Community Based Health Programme 2007-2010 implemented by the Sudan Regional Bishop Conference/SudanAid/National Health Unit for the NHU and three Dioceses in North and South Sudan (set up system phase). Lead Consultant</td>
</tr>
<tr>
<td>2007</td>
<td>Cordaid: 2nd mission: Development of a Monitoring and Evaluation system for the Community Based Health Programme 2007-2010 implemented by the Sudan Regional Bishop Conference/SudanAid/National Health Unit for the NHU and three Dioceses in North and South Sudan (testing and adjustment phase). Lead consultant</td>
</tr>
<tr>
<td>2007</td>
<td>For ZOA Refugee Care (ICCO and EU): Sudan Recovery and Rehabilitation Project (EU funded): Capacity Assessment of the County Health Department in Katigiri (Juba County), Southern Sudan. Lead Consultant.</td>
</tr>
<tr>
<td>2007</td>
<td>For Cordaid: Learning and linking mission of Cordaid support health programmes in Sudan (Darfur programme and identification of relevant issues for other programmes in Yambio, Juba, Kosti, El Obeid, and Nyamlell). Lead Consultant.</td>
</tr>
<tr>
<td>2007</td>
<td>For Cordaid: Evaluation of PHC/CBHC programme of SCBC/SudanAid/National Health Unit for IDPs and returnees in Juba Diocese (South Sudan) and Kosti and El Obeid Dioceses (North Sudan) and Strategic</td>
</tr>
<tr>
<td>Year</td>
<td>Description of Mission / Client</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>2007</td>
<td>For Cordaid/Caritas Swiss/UNICEF: Technical support to Diocese of Tombura-Yambio with the preparation of final phase participatory 5-year Strategic Health Plan (participatory formulation of Strategic Plan). Team leader.</td>
</tr>
<tr>
<td>2007</td>
<td>For ICCO, EED, and Caritas Australia: Resource person for Mid Term Evaluation of Christian Health Association for Sudan (CHAS) and participating in meetings and debriefing.</td>
</tr>
<tr>
<td>2007</td>
<td>For ICCO, EED, and Caritas Australia: Technical backstopping for institutional development of Church Health Association Sudan (CHAS). Facilitation of stakeholder workshop, establishment CHAS Advisory Committee, donor meetings, preparation TA plan and Mid Term Evaluation.</td>
</tr>
<tr>
<td>2006</td>
<td>For Cordaid/Caritas Swiss/UNICEF: Technical support to Diocese of Tombura-Yambio with the preparation of second phase participatory 5-year Strategic Health Plan (participatory formulation of Strategic Plan). Team leader.</td>
</tr>
<tr>
<td>2006</td>
<td>For Cordaid/Caritas Swiss/UNICEF: Technical support to Diocese of Tombura-Yambio with the preparation of first phase participatory 5-year Strategic Health Plan (situation analysis).</td>
</tr>
<tr>
<td>2006</td>
<td>ICCO/EED/Caritas: Capacity building support to institutional development of Church Health Association Sudan (CHAS). Facilitating capacity building workshop for church leaders and senior health managers. Focus on collaboration with MOH and development partners and development of institutional set-up of CHAS (development of governance bodies, advisory committee, regional networks, professional groups, membership criteria). Team leader.</td>
</tr>
<tr>
<td>2005</td>
<td>For ICCO/ICEAS/CHAS: Technical assistance with the development of CHAS (Church Health Association in South Sudan). Focus on situation analysis, stakeholder analysis, institutional setting, and potential role for CHAS, donor funding, policy developments and development of Strategic Plan for period 2005-2007. Team leader.</td>
</tr>
<tr>
<td>2004</td>
<td>For Cordaid/Caritas/UNICEF: Diocese of Tombura and Yambio, Technical support to Diocesan Health Programme: Focus on (1) Assessment of Pharmacy Management Systems in 2 hospitals and options for improvement, (2) Training in Management and Report writing skills, (3) Adjustment of Hospital HMIS system, (4) preparation of PHC programme, (5) capacity building to Diocesan health staff and Diocesan Health Executive Committee. Team leader.</td>
</tr>
<tr>
<td>2003</td>
<td>For Cordaid: Development of Capacity Building Plan for Diocesan Health Programme of Diocese of Tombura and Yambio. Main consultant.</td>
</tr>
<tr>
<td>2002</td>
<td>For HNI: Technical backstopping to (1) Assessment of Coordination Mechanisms for African Programme Onchocerciasis (APOC) for Southern Sudan and (2) formulation of capacity building and technical assistance plan for PSO. Principal backstopper and main consultant for the formulation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year: 1998-2001</td>
<td>Description of Mission / Client</td>
</tr>
<tr>
<td>2007</td>
<td>Cordaid and GLRA: Resource person for 2-day workshop on Leprosy and TB Policy for Southern Sudan (organised by German Leprosy and TB Association).</td>
</tr>
<tr>
<td>2001</td>
<td>Transformation from an international NGO to Ugandan NGO</td>
</tr>
</tbody>
</table>
- Institutional Development and Financial Management
- Preparation of Mid-Term Review
- Monitoring and Evaluation System
- Data Analysis and Report Writing
- Provision of update information
- Logical Framework Approach

Design of IEC Strategies.

1998

Country: Kenya

Year: Description of Mission / Client

2005
For ICCO/CHAS: Technical support to CHAS (Church Health Association Sudan) with (1) co-facilitating a 2-day workshop for Sudanese NGOs in the health sector, (2) co-preparation of concept paper on public-private collaboration with MOH, (3) preparation of workshop report and (4) preparation of TORs for diversified TA support to CHAS in 2006.

2004

2003
For DANIDA: Feasibility Study and Project Formulation for 3-year programme in (1) North Eastern Province (Somali pastoralist population), (2) 15 Districts and at (3) National level. Focus on SWAp, HMIS, Pharmaceutical support and IMCI. Team member.

2003
For Stichting Liliane Fonds (SLF): Assessment of options for registration as legal entity abroad and implications (legal, tax, employment) of SLF National Coordination Offices (support for disabled children and youth). Team leader (2 team members).

2002
For DGIS: Evaluation of Stichting Liliane Fonds SLF: programme for disabled children in development countries. Team leader (2 team members).

2001
For Cordaid: Facilitation of a 5-year strategic planning workshop and development of a multiple sector Logical Framework for Diocese of Ngong. Team Leader (3 team members).

2001
For Cordaid: External Evaluation of the social development programmes (health, education, micro enterprise, food security) in the Diocese of Ngong. Team leader (4 team members).

2001
For CAFOD/Cordaid: PHC Strategic Planning Workshop based on results from PHC program evaluation. Marsabit Diocese. Team leader (2 team members).

2000
For Cordaid: Joint Review and Analysis of Church/Mission Health Care Programmes vis-à-vis GOK Health Sector Reforms. Catholic Secretariat of Kenya and Christian Health Association of Kenya. Team member.

2000
For CAFOD/Cordaid: Evaluation of PHC/CBHC Programme in Samburu and Marsabit Districts in a pastoralist inhabited area (Samburu, Turkana, Pokot, and Borana). Catholic Diocese of Marsabit. Team leader (5 team members).

Country: Ethiopia

Year: Description of Mission / Client

2010
Micronutrient Initiative/FMOH: Development of a National Operational Plan for FMOH Ethiopia with the aim to facilitate the integration of the Enhanced Outreach Strategy (EOS) in the Health Extension Package (HEP) of Ethiopia. Technical Backstopper to regional firm (BIC).

2008
MOH/UNICEF: Mid Term Review of Ethiopia Health Sector Development Programme (HSDP III) with a focus on the Health Extension Package (HEP). Team member and assistant TL for the editorial team (50 consultants).

2006
ICCO, Oxfam/Novib, Cordaid, Plan and NGO IIRR: Development of 3-year Strategic Plan for NGO network (50NGOs) in Ethiopia for the development and implementation of HIV/AIDS Workplace Policies for NGOs that receive funding from Dutch Co-funding Agencies. Team leader.

2006
MOH/UNICEF: Review of National Health Sector in Ethiopia (HSPS II) with a team of 30 international and national consultants. In-depth review of Tigray and Amhara Regions and co-writing and editing of final report. Sub-team leader and assistant TL.

2003

2002

2001
For Cordaid: Formulation of 5-Year Diocesan Health Development Plan for Awasa Diocese. Team leader (2 team members).
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>For Cordaid: Formulation of a 3-year PHC Programme in a pastoralist inhabited area (Borana, Ghabra, and Guji). Dadim Catholic Mission in Awasa Diocese. Team leader (6 team members).</td>
</tr>
</tbody>
</table>

**Country: Zambia**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
</table>

**Country: Malawi**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Cordaid-ICCO-PSO- CHAM: Mid Term Review of Joint Capacity Building Programme (JCBP) for selected health partners of the Christian Health Association in Malawi (CHAM). Team leader (3 consultants).</td>
</tr>
</tbody>
</table>

**Country: Netherlands**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>KIT/Royal Tropical Institute: Thesis support to two MPH students (From Ethiopia and Ghana) on (1) impact of Malnutrition on under-5 children and (2) Breast feeding practices among HIV+ women.</td>
</tr>
<tr>
<td>2010</td>
<td>KIT/Royal Tropical Institute: Trainer on Health Management Information System (HMIS) for MIH/MPH/NTC students.</td>
</tr>
</tbody>
</table>

16. **List of publications upon request**

- More than 100 mission reports for a wide range of clients (1998-2010)
- Presentations and reports on various web sites (e.g. [www.hrresourcecenter.org](http://www.hrresourcecenter.org) and [www.interchurch.org](http://www.interchurch.org) (HRH connection))
- 2007: MT Bulletin of the Netherlands Society of Tropical Medicine and International Health (July 2007: Article: Christian Health Associations: How to achieve an award winning status?)
SUB-GRANT AGREEMENT

Between

INTERCHURCH MEDICAL ASSISTANCE, INC.
(d/b/a IMA World Health)
500 Main Street, Building – Old Main, Box 429
New Windsor, Maryland 21776-0429
Tel: 410-635-8720 Fax: 410-635-8726

And

ETC Crystal
Leusden, the Netherlands

This Sub-Grant Agreement (the “Agreement”), made this 17th Day of August 2010, is by and between Interchurch Medical Assistance, Inc., a Maryland, USA nonstock corporation (hereinafter referred to as the “Grantor” or “IMA World Health”), and ETC Crystal in Leusden, the Netherlands, (hereinafter referred to as the “Grantee”).

WITNESSETH

WHEREAS, IMA World Health’s primary mission is to advance health and healing to vulnerable and marginalized people by promoting programs aimed at strengthening health systems and supporting broad disease control and elimination initiatives in developing countries.

WHEREAS, in furtherance of its mission, IMA World Health has received a grant (the “Primary Grant”) from the Government of Southern Sudan represented by the Ministry of Health from a Multi-Donor Trust Fund (MDTF) provided by a consortium of donors which includes the International Development Association (“IDA” or the “Bank”) in support of the Umbrella Program for Health System Development being conducted in Southern Sudan (the “Program”).

WHEREAS, as part of the Program, IMA World Health is authorized to make sub-grants to qualified recipients for the furtherance of the program goals;

WHEREAS, the Grantee has sufficiently demonstrated that it is a qualified recipient to participate in this program;

WHEREAS, in furtherance of the Program, IMA World Health has entered into this Agreement with the Grantee.
NOW THEREFORE, the following is hereby declared and set forth:

1. **Recitals.** The foregoing recitals are made a part of this Agreement.

2. **Term of Agreement.** The Term of this Agreement will commence on the date first noted above and will continue until June 30, 2011.

3. **Purpose and Execution of the Sub-Grant.**

   3.1 **Specific Purpose.** The services to be provided by the Grantee will be outlined in the Scope of Work (Attachment A).

   3.2 **Execution of Sub-Grant.** The Grantee will carry out the purpose of the Sub-Grant with due diligence and efficiency; furnish all information covering such activities and the use of the proceeds of the Sub-Grant as the Grantor may reasonably request; and by providing a monthly report to the Grantor's representatives on the progress and results of the Sub-Grant, as specified in Paragraph 9.

   3.3 **Evaluation Missions.** The Grantee will be notified by the Grantor of all evaluation missions during and at the termination of the Sub-Grant. The Grantee will take all reasonable steps to assist representatives of the Grantor, GOSS/MOH, or the Bank to visit and study the various activities undertaken as part of the Sub-Grant.

   3.4 **Procedures Manual.** The Grantee will implement this project in accordance with program and financial administration procedures established in accordance with its Board and Management policies and procedures.

4. **Amount of Sub-Grant.** The Grantor hereby agrees to make a grant for the Term of Agreement, as specified in Paragraph 2, in an amount not exceeding $102,437 to the Grantee (Attachment B). Any grant made pursuant to this Paragraph 4 shall be hereinafter referred to as a “Sub-Grant”.

   4.1 Notwithstanding the foregoing, funding shall be available for the Term of Agreement as specified in Paragraph 2. Grantee may charge to the funds obligated under this Agreement, only allowable costs resulting from expense obligations incurred during the Term of Agreement.

   4.2 In the event that any of the proceeds of the Sub-Grant remain uncommitted at the end of the Term of Agreement, as specified in Paragraph 2, or such later date as the Grantor may otherwise agree, such funds shall be returned to the Grantor.

5. **Payment of Sub-Grant**

   5.1 **Quarterly Payment.** The Grantor hereby agrees to make quarterly payments to the Grantee for the Term of Agreement contingent on satisfactory performance of the
activities agreed in this Agreement via a completed request for payment form and an expenditure report, as specified in Paragraph 9.1, subject to performance verification.

5.2 **Bank Account for the Sub-Grant and Withdrawal Applications.** The Sub-Grant will be disbursed into the Grantee’s bank account as specified below:

- **Bank:** Triodosbank
- **Bank Address:** P.O. Box 55
  - NL-3700 AB Zeist
  - The Netherlands
- **Account No:** 21.21.75.017
- **Swift Code:** TRIONL2U
- **Beneficiary's name:** ETC Nederland BV
  - PO Box 64
  - NL-3830 AB Leusden
  - The Netherlands

5.3 **Investment Income.** All investment income, if any, earned by the Grantee on the Sub-Grant funds actually held by the Grantee will be added to the Sub-Grant for use by the Grantee for the purpose of the Sub-Grant. The Grantee shall report the amount of earnings on the Sub-Grant and add it to the Sub-Grant on a quarterly and cumulative basis.

6. **Procurement.**

6.1 **Consultants’ Services.** Before the Grantee procures the services of any consultants with Sub-Grant funds, the Grantee must first seek the Grantor’s approval of the procurement process to ensure that it complies with the Bank’s procedures that govern the Primary Grant.

6.2 **Review of Procurement Decisions.** All procurement decisions made by the Grantee with respect to the Sub-Grant funds are subject to review by the Grantor.

7. **Budget.**

7.1 **Proposed Expenditures.** Before any Sub-Grant funds are advanced to the Grantee, the Grantee must provide the Grantor with a detailed budget (*Attachment B*), demonstrating how the Sub-Grant funds will be expended. The budget must capture the categories of expenses and the amounts allocated to each category. The budget must be approved by the Grantor. Any variances exceeding 10% of the budgeted categories of expenses must be approved by the Grantor.

7.2 **Prohibited Expenditures.** No portion of the Sub-Grant funds may be used for (a) payments for expenditures made in connection with the Project prior to the date of this Agreement; or (b) payment for commitments made in connection with the Sub-Grant.
after its termination, or such later date as the Grantor establishes by written notice to the Grantee.

7.3 Prohibition Against Terrorist Financing. By executing this Agreement, Grantee certifies that it has not provided and will not provide material support or resources to any individual or entity that it knows, or has reason to know, is an individual or entity that advocates, plans, sponsors, engages in or has engaged in terrorist activity.


8.1 Financial Management System. The Grantee will maintain or cause to be maintained a financial management system, including records and accounts, and prepare financial statements in a format acceptable to the Grantor, adequate to reflect, in accordance with generally accepted accounting principles in the United States, the operation, resources and expenditures related to the purpose of the Sub-Grant. The Grantee will provide the Grantor with access to these records, accounts, and statements for the purpose of inspecting the same, and the Grantor is entitled to copies of the same as they relate to the use of Sub-Grant funds. The Grantee shall also provide the Grantor with such other information concerning the records, accounts, and statements as the Grantor may from time to time reasonably request.

8.2 Audit. The Grantor reserves the right, on reasonable notice to the Grantee and at the Grantor’s sole cost, to require an audit of the Grantee’s records and accounts as they relate to the activities funded by the Sub-Grant.

9. Grantee Monitoring Reports

9.1.1 Monthly Financial Reports. For the Term of this Agreement, the Grantee will prepare and furnish to the Grantor monthly financial reports per the format provided in (Attachment B). The financial report should summarize the activities financed under the Sub-Grant during the reporting period.

9.1.2 Program Technical Reports. The Grantee will also prepare and furnish to the Grantor technical program progress and narrative reports assessing the results achieved against the objectives of the Sub-Grant at the end of each of the implementation phases 1-3 that they have outlined in their proposal.

9.1.3 Reports Due. These reports should be in English and received by the Grantor by the 7th of the month following the reporting month.

9.2 Audited Statements. The Grantee will provide to Grantor a copy of its most recent audited statement on signing the agreement, and a copy of each subsequent audited statement that includes activities financed under this Sub-Grant.
9.3 Final Report. The Grantee will prepare and furnish to the Grantor not later than forty-five (45) days after the completion of the Sub-Grant a final financial report summarizing the activities financed under this Sub-Grant and a narrative report assessing the results achieved against the objectives of the Sub-Grant.

10. Reversion of Sub-Grant.

10.1 Suspension of Further Withdrawals. The Grantor may at any time, by notice to the Grantee, suspend further withdrawals from the Sub-Grant account if any of the following events has occurred: (a) Sub-Grant funds withdrawn have not been used for the purpose of the Sub-Grant; (b) the Sub-Grant has not been carried out by the Grantee in accordance with the standards or methods specified herein; or (c) the Grantee has not complied with any of the obligations herein specified.

10.2 Cancellation of the Sub-Grant. The Grantor may, by notice to the Grantee, cancel any amount of the Sub-Grant remaining not withdrawn: (a) at any time after withdrawals from the Sub-Grant account have been suspended pursuant to the provisions of Section 10.1; or (b) if the Grantee fails to take action, satisfactory to the Grantor, regarding the implementation of the Sub-Grant within four (4) months of the date of this Agreement. In the event that the Grantor terminates payment of the Sub-Grant pursuant to this Paragraph 10.2, the Grantor shall have no further liability of any kind to the Grantee.

10.3 Termination. This Agreement may be terminated by mutual consent or by either party on sixty (60) days notice in writing to the other party. Notwithstanding the above, the Grantor may terminate this Agreement immediately upon written notice to the Grantee if the Primary Grant is terminated. The Grantee will not be obligated to repay any funds irrevocably committed in good faith to third parties before the agreed date of termination, or in the case of termination by either of the parties, before the date of receipt by the other party of the written notice of termination. All Sub-grant funds on hand and in the bank which has not been committed are to be refunded to the Grantor when the Agreement is terminated. Except as otherwise provided in this Paragraph, in the event of the termination of this Agreement, the Grantor shall have no further liability of any kind to the Grantee.

11. Miscellaneous.

11.1 Sub-Grant Not Assignable. The Sub-Grant herein made is intended solely for the Grantee and for the purpose described herein. No right to receive Sub-Grant funds hereunder may be delegated, assigned or otherwise hypothecated or transferred without the advance, written consent of the Grantor, which consent shall be in the sole and absolute discretion of the Grantor.

11.2 Applicable Law. It is understood that all parties providing services for the implementation of the work for the program will abide by the local laws of South
Sudan. This Agreement shall be construed and governed by the laws of the State of Maryland in the United States of America.

11.3 **Interpretation.** This Agreement shall be interpreted in a manner consistent with the agreement governing the Primary Grant.

11.4 **Indemnification.** The Grantee shall hold harmless and indemnify the Grantor and its officers, directors, shareholders, agents, employees, successors and assigns from and against any and all losses, expenses, judgments, settlements, claims, attorneys' fees and damages arising out of any claim relating to or arising out of (or alleged to be relating to or arising out of) this Agreement; provided, however, that the Grantee shall not be required to hold harmless or indemnify Grantor for any claim arising out of a breach of this Agreement by Grantor or any other wrong of Grantor.

This obligation of the Grantee to hold harmless and indemnify the Grantor shall survive termination of this Agreement for so long as any potential for liability under applicable law, rule ordinance statute or judicial decision remains. In this regard, the Grantee waives the effect of any statute of limitation that should by lapse of time, limit the Grantee's indemnification obligations.

11.5 **Force Majeure.** Neither party shall be deemed to be in violation of this Agreement if it is prevented from performing or hindered in its performance of any of its obligations hereunder for any reason beyond its control, including, without limitation, strikes, lockouts, unavailability, shortages or delays in delivery of material or equipment, acts of God, or any statute, regulation or rule of the Federal, any state or local government, or any agency thereof, now or hereafter in force.

**Attachments:**

A: Scope of Work (3.1)
B: Approved Sub-Grant Budget (4); (7.1) & Monthly Financial Report Format (9.1.1)
IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first written above.

Witness/Attest:

Interchurch Medical Assistance, Inc.
(IMA World Health)
(Grantor)

By: ____________________________
   Elizabeth Ojaba, Chief of Party

Date: __________________________

E T C Crystal
(Grantee)

By: ____________________________
   Name: __________________________
   Title: __________________________
   Date: __________________________
# APPENDIX 5 RESOURCE PERSONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Elizabeth Ojaba</td>
<td>IMA Worldhealth</td>
<td>Chief of Party Southern Sudan</td>
</tr>
<tr>
<td>Dr. Joy Mukaire</td>
<td>Church Health Association Sudan (CHAS)</td>
<td>Director</td>
</tr>
<tr>
<td>Dr. Elias Mstiale</td>
<td>Norwegian People Aid (NPA)</td>
<td>MDTF Coordinator</td>
</tr>
<tr>
<td>Dr. Gribani Kameri</td>
<td>Norwegian People Aid (NPA)</td>
<td>Director Southern Sudan Programme</td>
</tr>
<tr>
<td>Dr. Samuel Baba</td>
<td>Ministry of Health GOSS</td>
<td>Director General External Relations and Coordination</td>
</tr>
<tr>
<td>Dr. Angkok</td>
<td>Ministry of Health GOSS</td>
<td>Director General Primary Health care</td>
</tr>
<tr>
<td>Dr. A.M. Abubakar</td>
<td>World Health Organisation</td>
<td>MO WHO</td>
</tr>
<tr>
<td>Dr. Sara</td>
<td>Ministry of Health GOSS</td>
<td>Directorate Human Resource Development</td>
</tr>
<tr>
<td>Dr. Richard Lako</td>
<td>Ministry of Health GOSS</td>
<td>Director Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>Dr. G. Murindwa</td>
<td>Ministry of Health GOSS</td>
<td>Technical Assistant to Health Priorities</td>
</tr>
<tr>
<td>Dr. Peter Makol</td>
<td>Jonglei State Ministry of Health</td>
<td>Acting Director General / Surgeon Bor State Hospital</td>
</tr>
<tr>
<td>Dr. A. Makina</td>
<td>IMA Worldhealth</td>
<td>Team Leader Jonglei</td>
</tr>
<tr>
<td>Dr. T. A. Lavrick</td>
<td>IMA Worldhealth</td>
<td>Deputy Team Leader Jonglei</td>
</tr>
<tr>
<td>Mr. E. Masbay</td>
<td>IMA Worldhealth</td>
<td>Finance Officer Jonglei</td>
</tr>
<tr>
<td>Mr. S. Manyiel</td>
<td>Bor County</td>
<td>County Medical Office</td>
</tr>
<tr>
<td>Mr. Gabriel Deng</td>
<td>South Sudan Relief &amp; Rehabilitation Commission (SSRRC)</td>
<td>Director General Jonglei State</td>
</tr>
<tr>
<td>Dr. John Kok Ayon</td>
<td>Sudan Medical Care (SMC)</td>
<td>Program Director</td>
</tr>
<tr>
<td>Dr. A.A. Kuchkon</td>
<td>Memorial Christian Hospital</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>Mr. T. Dannan</td>
<td>John Dau Foundation</td>
<td>Executive Director and Project Manager</td>
</tr>
<tr>
<td>Dr. D. M. T. Duop</td>
<td>IMA Worldhealth</td>
<td>Deputy Team Leader Jonglei</td>
</tr>
<tr>
<td>Mrs. N. Stoops</td>
<td>Health Information Systems Programme (HISP)</td>
<td>Senior Facilitator</td>
</tr>
<tr>
<td>Mr. M. Ali</td>
<td>IMA Worldhealth</td>
<td>M&amp;E Officer</td>
</tr>
<tr>
<td>Mr. C. G. Deng</td>
<td>Upper Nile State, Longechuk County health Department</td>
<td>County Health Officer</td>
</tr>
<tr>
<td>Mr. A. J. Thubo</td>
<td>Upper Nile State, Fashoda County Health Department</td>
<td>County Health Officer</td>
</tr>
<tr>
<td>Mr. B. S. Mach</td>
<td>Upper Nile State, Renk County Health Department</td>
<td>County Health Officer</td>
</tr>
<tr>
<td>Mr. M. M. Awau</td>
<td>Upper Nile State, Melut County Health Department</td>
<td>County Health Officer</td>
</tr>
<tr>
<td>Mr. Y. Arop</td>
<td>Upper Nile State Ministry of Health</td>
<td>Deputy Director Primary health Care Services</td>
</tr>
<tr>
<td>Mr. A. Kurdit</td>
<td>Upper Nile State Ministry of Health</td>
<td>Director Curative Service, Acting Director General</td>
</tr>
<tr>
<td>Mr. P. Okech Adak</td>
<td>Upper Nile State Ministry of Health</td>
<td>Director Expanded Program of Immunization (EPI)</td>
</tr>
<tr>
<td>Mr. B. Mano</td>
<td>International Medical Corps (IMC)</td>
<td>Site Manager Malakal</td>
</tr>
<tr>
<td>Mr. E. B. Mehari</td>
<td>International Relief and Rehabilitation (IRD)</td>
<td>Programme Manager Upper Nile State</td>
</tr>
<tr>
<td>Mr. C. Ayella</td>
<td>USAID health education &amp; reconciliation Project, Rumbek State</td>
<td>M&amp;E Technical Advisor</td>
</tr>
<tr>
<td>Dr. Mamude Dinkaye</td>
<td>Norwegian People Aid (NPA)</td>
<td>Team Leader MDTF Programme</td>
</tr>
<tr>
<td>Mr. W. Groenendijk</td>
<td>Basic Services Fund Secretariatdan (BSF) - BMB Mott MacDonald</td>
<td>Policy Development, M&amp;E Officer</td>
</tr>
<tr>
<td>Dr. A. N. Rieck</td>
<td>Norwegian People Aid (NPA)</td>
<td>Deputy Team Leader MDTF Programme</td>
</tr>
<tr>
<td>Dr. G. W. Lutwama</td>
<td>IMA Worldhealth</td>
<td>Technical Advisor HIV/AIDS</td>
</tr>
</tbody>
</table>
APPENDIX 6 RESOURCE DOCUMENTS

- Accelerated Child Survival Initiative - Upper Nile State, 2010, Minutes Steering Committee, 16 February
- ETC Crystal, 2010, SuddHealth project, Strengthening Health Systems South Sudan, Technical Support to Health Sector Steering Committees, Concept Paper + accompanying letter
- GoSS, 2005, Final CPA
- HISP, 2009, States in Development: State Building and Service Delivery
- HISP, 2010, South Sudan Visit 1 Report
- IMA, 2008, Memorandum of Understanding between ETC Crystal and IMA World Health
- IMA, 2008, Technical Proposal, in response to: Umbrella Program for Health System Development, Lead Agencies to Deliver the Basic Package of Health Services (BPHS) in Selected States – Upper Nile (RFP No (MOH-06D/06/GoSS/CS), Form Tech-4
- IMA, 2008, Technical Proposal, in response to: Umbrella Program for Health System Development, Lead Agencies to Deliver the Basic Package of Health Services (BPHS) in Selected States – Jonglei Nile (RFP No (MOH-06D/06/GoSS/CS), Form Tech-4
- IMA, 2008, Lead Agency for The Umbrella Program for Health System Development – Upper Nile State, an MDTF-funded project, inception report
- IMA, 2008, Lead Agency for The Umbrella Program for Health System Development – Jonglei State, an MDTF-funded project, inception report
- IMA, 2009, SANRU, Training Modules for Health Systems Strengthening of Health District Teams
- IMA, 2009, Minutes SuddHealth Consortium Meeting
- IMA, 2010, SuddHealth Project Overview
- IMA, 2010, SuddHealth, Draft Terms of Reference for ETC Crystal
- IMA, 2010, Sub-Grant Agreement between IMA and ETC Crystal
- IMA, 2010, Update to IMA Technical Partners on Status of the Contracts for Jonglei and Upper Nile States
- Jonglei State, 2010, Minutes of the NGO Forum, 18 March
- Jonglei State, 2010, Minutes Health Coordination Meeting, 4 May
- Jonglei State, 2010, Minutes Inter-agency meeting, 24 February
- Jonglei State, 2010, Minutes HIV/AIDS Coordination Meeting, 18 March
- Jonglei State, 2010, Minutes HIV/AIDS Commission, 2nd Quarter Coordination Meeting, 29 June
- MoH, 2009, Guidelines for County Health Departments
- MoH, 2009, Basic Package of Health Services
- MoH, 2009, M&E Framework
- MoH/LATH, 2009, Health Performance Mapping: State Ministries of Health Southern Sudan
- MoH/LATH, 2010, Strengthening Communications in Health
- Norad, 2009, Mid-Term Evaluation of the Joint Donor Team in Juba, Sudan
- NGO Health Forum, 2010, Minutes of meeting 29 July
- NPA, 2009, Role of the NPA as a Corporate Project Sponsor (Lead Agency), internal NPA document
- NPA, 2010, Minutes of the 5th Steering Committee Meeting of the NPA/MDTF-Health Project in Central Equatoria State
- SMC, 2009, Profile, Sudan Medical Care
- UN, 2010, MDGs in South Sudan
- Upper Nile State, 2009, Minutes Health Sector Meeting, 25 June
- Upper Nile State, 2009, Minutes Health Sector Meeting, 27 May
- Upper Nile State, 2009, Minutes Health Sector Meeting, 11 February
- Upper Nile State, 2010, Minutes Health Coordination Meeting, 24 March
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.08.10</td>
<td>Travel Amsterdam - Nairobi</td>
</tr>
<tr>
<td>23.08.10</td>
<td>Travel Nairobi - Juba; initial meeting at IMA Office</td>
</tr>
<tr>
<td>24.08.10</td>
<td>Juba - Interview Resource Persons</td>
</tr>
<tr>
<td>25.08.10</td>
<td>Juba - Interview Resource Persons</td>
</tr>
<tr>
<td>26.08.10</td>
<td>Travel Juba - Bor, Interview Resource Persons</td>
</tr>
<tr>
<td>27.08.10</td>
<td>Bor - Interview Resource Persons</td>
</tr>
<tr>
<td>28.08.10</td>
<td>Bor - Workshop with IMA Staff</td>
</tr>
<tr>
<td>29.08.10</td>
<td>Bor - Drafting Findings &amp; Recommendations</td>
</tr>
<tr>
<td>30.08.10</td>
<td>Travel Bor - Juba, Interview Resource Persons</td>
</tr>
<tr>
<td>31.08.10</td>
<td>Travel Juba - Malakal, Interview Resource Persons</td>
</tr>
<tr>
<td>01.09.10</td>
<td>Malakal - Interview Resource Persons</td>
</tr>
<tr>
<td>02.09.10</td>
<td>Travel Malakal - Juba, Interview Resource Persons</td>
</tr>
<tr>
<td>03.09.10</td>
<td>Juba - Interview Resource Persons, de-briefing IMA</td>
</tr>
<tr>
<td>04/05.09.10</td>
<td>Travel Juba - Nairobi - A'dam</td>
</tr>
</tbody>
</table>
APPENDIX 8  NGOs Operational in Jonglei State

International NGOs
- ADRA
- AED
- CARE International
- Carter Centre - Health
- CHF
- Coopi
- COSV
- CRS
- DCA
- Handicap International
- INTERSOS
- IMA World Health
- IMC International Medical Corps
- IRD
- LWF / DCA
- Merlin
- MSF-Belgium
- MSF Holland
- Pact Sudan
- Peace Winds Japan
- PHO
- Save the Children Sweden
- Save the Children UK
- Tearfund
- VSF-Belgium
- WCS

National CSOs
- Barmach Community Development and Peace Network
- Bor County Youth Association
- Care for Children & Old Age in South Sudan (CCOSS)
- Christian Initiative for Development and Assistant Relief Mission (CIDRAM)
- Christian Recovery & Development Agency (CRADA)
- Church and Developmental Child Foundation (CDCF)
- Community Democratisation Initiative
- Duk United Youth Centre For Development
- Duk Women Resource Centre for Development
- Gogolten Development Agency
- Nile Hope Development Forum
- Nuer Council Foundation Trust Organisation
- Raise Hope Child care
- Sudan Christian Development & Rehabilitation Organisations
- Sudan Christian Mission(SCM)
- Sudan Medical Care
- Upper Nile Women Welfare Association
- Upper Nile Youth for Peace & Development Agency
ANNEX F9: PERFORMANCE MAPPING JONGLEI STATE

STATE PROFILE

JONGLEI

Capital: Bor
Counties (11): Old Fangak, Korfulus, Ayod, Dut, Wuror, Nyirol, Akobo, Pochalia, Pibor, Twic East, Bor South
County visited: Bor South
Population (approx.): 800,000 (1983)
Area: 122,479 km²

VITAL STATISTICS (GOVERNMENT OF SOUTHERN SUDAN, SUDAN HOUSEHOLD HEALTH SURVEY, 2006):

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality rate/1000</td>
<td>38.3</td>
</tr>
<tr>
<td>Post neonatal mortality rate/1000</td>
<td>38.5</td>
</tr>
<tr>
<td>Infant Mortality rate/1000</td>
<td>73.8</td>
</tr>
<tr>
<td>Under five mortality rate/1000</td>
<td>107.8</td>
</tr>
<tr>
<td>Child Mortality rate/1000</td>
<td>36.7</td>
</tr>
<tr>
<td>Maternal Mortality rate/100000</td>
<td>1861</td>
</tr>
<tr>
<td>Delivery by skilled personnel (%)</td>
<td>8.3</td>
</tr>
<tr>
<td>Delivery by traditional birth attendant (%)</td>
<td>10.6</td>
</tr>
<tr>
<td>Child malnutrition*underweight prevalence (% below-3SD)</td>
<td>39.5</td>
</tr>
<tr>
<td>Exclusive Breastfeeding 0-6 months (%)</td>
<td>19.4</td>
</tr>
<tr>
<td>Breastfeeding 6-9 months (%)</td>
<td>13.2</td>
</tr>
<tr>
<td>Use of improved water sources and sanitation (%)</td>
<td>22.2</td>
</tr>
<tr>
<td>Adult literacy (%)</td>
<td>2.1</td>
</tr>
<tr>
<td>Availability of insecticide nets in household (%)</td>
<td>38.8</td>
</tr>
<tr>
<td>Vaccination: Polio 3 (%) @ 12-23 months</td>
<td>17.6</td>
</tr>
<tr>
<td>Vaccination: MMR (%) @12-23 months</td>
<td>19.7</td>
</tr>
</tbody>
</table>
POLICY, PLANNING AND MANAGEMENT

1.1 Organisation Structure

3) Actual SMOH organogram Jonglei State

As the above comparison shows, the actual organisation structure in Jonglei State Ministry of Health (SMOH) is not fit for purpose. There is such a chronic shortage of staff at Jonglei SMOH that it is an undeniable challenge to achieve the mission, goals, and objectives of the Ministry of Health or to carry out the role of a SMOH defined in the 2007-2011 Health Policy (p14-16, and p48). There is an overwhelming workload on the Director General in particular, as he is carrying additional responsibilities for the core function Directorates of Primary Health Care, Preventive and Curative Medicine, which are all vacant.

4) Actual CHD organogram, Bor County, Jonglei

As the above comparison shows, the actual organisation structure in Bor County does not mirror the 2009 BPHS recommended structure. For example, the County Public Health Officer is combining two functions (Disease Surveillance and Nutrition); the County Medical Officer is carrying out an additional function (M&E); there is no department for Nursing; they have added a department for Finance & Admin, and added a function of Human Resources to the County Medical Officer’s responsibilities. However, the CHD is trying hard to fulfil the role of a CHD with the available staff resources (the role as defined in the 2007-2011 Health Policy) “We cannot create our own structure. We are working on what is helping Health Service Delivery until that structure comes”.

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7) MOH-GOSS HRD Directorate should urgently support SMOH Jonglei to fill vacancies

8) Human Resource Development: LATH should strengthen the capacity of MOH-GOSS HRD Directorate to support SMOH Human Resources Department through:
- developing a 1-year action plan to put HR policy into practice;
- developing and issuing job descriptions;
- orientation on staff management from the 2008 HR manual;
- regular emails;
- regular visits to SMOH and CHDs
- annual meetings for HR staff
- designing & implementing a staff training plan to include Accelerated programme of upgrading qualifications, and regular in-service training and mentoring on-site and through local institutions.

9) Financial Management: LATH should strengthen the capacity of MOH-GOSS Finance & Admin Directorate to:
- develop a financial management manual;
- provide in-service training and ongoing support through regular visits and annual meetings to F&A staff at SMOH & CHD level in
  - budgeting, defending budgets, monitoring expenditure against budgets, and financial reporting
  - monitoring amounts budgeted, approved, and disbursed
- clarify flow of funds, and ask MOH-GOSS and State Ministers of Health to follow up any delays; and
- accelerate upgrading qualifications in budgeting and accounting for F&A staff at SMOH & CHD level.

10) Policy Implementation: LATH should strengthen the capacity of all MOH-GOSS Directorates that produce policies to:
- to support SMOH to develop a plan for rolling out each new policy or guideline;
- develop indicators to monitor and evaluate the extent to which the policy has been put into practice;
- monitor SMOH policy implementation;
- analyse lessons learned and feed them back into policy reviews.

11) Planning and Management: Strengthen capacity of MOH-GOSS Planning Directorate to train and provide ongoing support to SMOH/CHD in planning, monitoring, and reporting.

12) Coordination: Contract a Governance Technical Advisor to help MOH-GOSS to review organisation structure, decision making and coordination mechanisms, and define composition and role of all committees, task forces and working groups.

13) Communication and Coordination: Provide communication equipment appropriate for Jonglei (internet, Skype, telephones, radio, boats, etc). MOH-GOSS Directorates regularly visit all SMOHs and CHDs.

14) Health Service Delivery: Strengthen capacity of MOH-GOSS PHC Directorate to support SMOH PHC Departments to
- develop a plan for rolling out the BPHS (see 4 above)
- plan for infrastructure, staff, drugs and supplies and referral systems to support the BPHS
- plan, organise, coordinate and supervise BPHS delivery;
- improve community participation in State, County and Facility Management Committees;
- Map NGO exit strategies and plan for SMOH/CHD to take over eventually.
<table>
<thead>
<tr>
<th>Current scenario</th>
<th>Factors affecting performance</th>
<th>Needs Identified/ *expressed</th>
<th>Priorities for capacity strengthening</th>
</tr>
</thead>
</table>
| **Capacity to implement MOH-GOSS policies and guidelines**<br>The SMOH had received some copies of the 2007-2011 Health Policy and several other policies & guidelines. However, they had not received orientation from MOH-GOSS or in turn organised any orientation sessions for lower levels (e.g. CHDs, payams or bomas).<br>At County level, the CMO had one copy of Health Policy but no orientation from SMOH, and had not run any orientation sessions for HFs, payams or bomas.<br>No evidence of<br>- capacity to analyse strengths and weaknesses of a Policy;<br>- plans to monitor successful implementation of the Health Policy;<br>- plans for SMOH/CHD to participate in revising the Health Policy after 2011. | Copies of 2007-2011 Health Policy not distributed until early 2009. Supply appears random (often via NGOs).<br>No orientation organised at State or County level, about the Health Policy or any other policies developed by MOH-GOSS since 2006 (including 2007 MRH, 2007 Essential medicines, 2007-2017 HR, Malaria Control, 2008 M&E, 2009 BPHS).<br>Lack of strategy /plan on how to translate policies into action, and monitor their implementation. | *SMOH need<br>- staff resources in SMOH to supervise policy implementation;<br>- Financial resources to implement policy;<br>- Vehicles to supervise implementation.  
*More copies of Health Policy to distribute to each CHD, Health Facility, Payam & Boma.  
Orientation/Awareness campaign: by SMOH for CHDs, and by CHDs for each HF and CHWs. | Identify Directorate responsible for encouraging translation of policies into practice (Research, Planning, & HSD).  
Strengthen the capacity of all relevant MOH-GOSS Directorates** to:<br>- Develop strategy/plan to support SMOH to roll out each new policy;<br>- Develop indicators to monitor and evaluate the extent to which policies have been put into practice;<br>- Monitor SMOH policy implementation;<br>- Use lessons learned to feed back into policy reviews.  
(** including Directorates of<br>- PHC,<br>- Preventive Medicine,<br>- Curative Medicine,<br>- Pharmacy,<br>- Human Resources,<br>- M&E.)<br>Allocate budget and strengthen the capacity of SMOH to roll out any new policies (orient/raise awareness about policy, develop action plans, monitor policy implementation, and feed back in to policy reviews). |
### Decentralisation of Planning, Management and Decision Making

<table>
<thead>
<tr>
<th>Current Scenario</th>
<th>Factors Affecting Performance</th>
<th>Needs Identified/Expressed</th>
<th>Priorities for Capacity Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision making</strong> has not been decentralised from GOSS to State level to any great extent. The SMOH believe that MOH-GOSS has the main decision making power in key areas like budgeting, revenue allocation, salaries, training; setting norms and standards and regulation; contracting service providers; payment mechanisms; medicines and supplies; vehicles and equipment; facilities and infrastructure; and HMIS design.</td>
<td>Lack of clarity about decentralisation in terms of decision making powers at different levels.</td>
<td>Definition of roles and responsibilities of decision making bodies at each level (including roles of State &amp; GOSS Assembly, GOSS-MOFEP and SMOH-MOFEP).</td>
<td>Governance Technical Advisor to strengthen the capacity of MOH-GOSS to review its organisation structure; define functions, roles and responsibilities, and coordination mechanisms.</td>
</tr>
<tr>
<td><strong>However, the State-level has powers to make decisions about expenditure management, HR contracts, and service delivery (facility management, defining service packages, monitoring service providers). At State level it is the State Minister of Health who has the major influence in decision making.</strong></td>
<td>Composition and Roles not defined for State/County/Health Facility or Village Health Management Committees.</td>
<td><em>Proper staff and tools to carry out tasks of planning and reporting.</em></td>
<td>Establish State / County/Health Facility/Village Health Management Committees, clarifying committee composition and roles.</td>
</tr>
<tr>
<td><strong>There is no State Health Management Committee in Jonglei; and no County Health Management Committee in the county visited.</strong></td>
<td>Lack of training and ongoing support for SMOH/CHD in planning and budgeting, monitoring, reporting and accounting.</td>
<td><strong>2008 HR Manual not distributed or put into practice.</strong></td>
<td>Strengthen the capacity of MOH-GOSS Directorates of Research Planning &amp; HSD and Finance &amp; Admin to provide training and ongoing support to SMOH and CHD in planning and budgeting, monitoring, reporting and accounting.</td>
</tr>
<tr>
<td><strong>Planning, M&amp;E:</strong> There appeared to be little institutionalised understanding of planning, management, monitoring and evaluation except among individuals who had previously worked for NGOs. The DG said they had the same Plan of Action repeated every year. Reporting formats are not standardised. NGOs use the report format designed by MOH-GOSS but other health units “use any small paper”. Although the CHD visited had a number of departmental quarterly work plans, they said “We didn’t do an Annual Plan because we are waiting for the IMA [Lead Agency] Plan”. The post of Director M&amp;E is vacant.</td>
<td><strong>Urgent need for staff in SMOH Directorates.</strong></td>
<td>Develop indicators to show how SMOH &amp; CHD capacity to plan and report has been improved.</td>
<td>Strengthen MOH-GOSS support and supervision to SMOH DGs.</td>
</tr>
<tr>
<td><strong>Management:</strong> There was insufficient evidence that the SMOH/CHD has staff management procedures in place (e.g. for recruitment, induction, job descriptions, line management, technical support, regular supportive supervision and performance appraisals, staff mentoring and training plans, grievance and disciplinary issues, etc) even though most issues are well covered in the 2008 HR Manual.</td>
<td></td>
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</tr>
<tr>
<td>Current scenario</td>
<td>Factors affecting performance</td>
<td>Needs identified/ *expressed</td>
<td>Priorities for capacity strengthening</td>
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<tr>
<td>Although there is apparently a manual at SMOH covering financial controls and procedures, it is unclear whether this specifies who should be involved in preparing and approving budgets, or obligations for timely disbursement of funds. Financial training is ad hoc. The SMOH Director of Finance &amp; Admin had some training in procurement. The CHD Finance &amp; Admin Officer had attended finance &amp; budgeting training in Kenya. SMOH prepared a “needs-based” budget using information provided by CHDs, which the State Assembly approved. GOSS later cut the budget so SMOH did not receive the amount requested. (They only received Chapter 1 for Salaries, and nothing for Chapters 2-4 for running costs and capital). The CHD income was SDG 11,000; sources were MOH-GOSS SDG 7,500 for 21 salaries and the County Commissioner 3,500 for other salaries. It is not possible to comment on efficient use of resources for effective health system delivery when there is such a chronic shortage of funds to supervise and deliver services. Salaries are not paid on time (with 2 or more months delay), which is very demotivating for staff.</td>
<td>Limited capacity to prepare budgets, monitor expenditure against budget, and demonstrate transparency, accountability and efficient use of resources. Lack of financial qualifications. SMOH/CHD unable to carry out function because no funds for operational costs. Large variation between amount budgeted, amount approved, and amount disbursed Lack of political will to decentralise budget approval and timely disbursement of funds from GOSS level to State level.</td>
<td>*Training in financial management. *Provide SMOH 6 months running/operational costs in advance. *CHD should have their own budget and bank account, and receive funds directly from MOFEP.</td>
<td>Strengthen the capacity of MOH-GOSS Finance &amp; Admin Directorate to: - Develop/update financial procedures manual. - Provide on-the-job training and ongoing support to F&amp;A staff at SMOH &amp; CHD, especially in needs-based budgeting; monitoring flow of funds/ disbursements; monitoring expenditure against budget; and demonstrating cost-effectiveness. Clarify flow of funds and obligations with GOSS Assembly &amp; MOFEP; monitor delays, and ask MOH-GOSS Minister and State Ministers to follow up any delays. Upgrade qualifications in accounting for F&amp;A staff at SMOH &amp; CHD level.</td>
</tr>
</tbody>
</table>

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## Coordination Mechanisms

<table>
<thead>
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<th>Factors affecting performance</th>
<th>Needs identified/ *expressed</th>
<th>Priorities for capacity strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further information is needed on existing coordination mechanisms, frequency, and issues discussed. However, it appears there does not seem to be any written guidance on Intra-departmental coordination, inter-level coordination, or Coordination with external partners. As a result coordination arrangements seem to be ad hoc. Inside SMOH the chronic shortage of staff hampers inter-departmental meetings. There seems to be inadequate coordination between MOH-GOSS and SMOH, but much more contact between SMOH and CHDs, especially between those within a day’s travel to the State capital. Further information is needed on coordination mechanisms with external partners, including NGOs. IMA Worldwide was appointed Lead Agency for NGO service delivery of BPHS in late 2008 but has mostly focussed on two counties to date. There is a serious lack of communication infrastructure (e.g. internet, telephones, radio) needed in such a large State as Jonglei.</td>
<td>Lack of job descriptions that clarify reporting in terms of management lines and coordination lines. Lack of clarity about composition &amp; roles of various coordination committees, including GOSSHA I &amp; II (2007-2011 Health Policy does not mention all).</td>
<td>Fill vacancies in SMOH.</td>
<td>Governance Technical Advisor to strengthen the capacity of MOH-GOSS to review its coordination mechanisms (internal and external) and define composition and roles of all committees, task forces and working groups (including frequency of meetings and issues to be discussed). MOH-GOSS Directorates should plan regular visits to all SMOH and CHDs to provide ongoing support and technical advice. <em>Provide communication equipment (Thuraya phones suggested).</em> Provide alternative forms of transport (boats, hire planes).</td>
</tr>
<tr>
<td>Current scenario</td>
<td>Factors affecting performance</td>
<td>Needs identified/ *expressed for HR Development</td>
<td>Priorities for capacity strengthening</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>At SMOH level, the Admin Director is responsible for Human Resources (HR), and he has a Human Resources Officer in the department. At CHD level the CMO covers HR.</td>
<td>Lack of MOH-GOSS strategy to support SMOH to put the HR policy into practice.</td>
<td>*To improve the flow of information about policies.</td>
<td>Strengthen the capacity of MOH- GOSS HRD Directorate to support SMOH Human Resources Department through:</td>
</tr>
<tr>
<td>There was no mention of the 2007-2017 Strategic Plan for HR; or the 2008 HR Manual.</td>
<td>Lack of qualifications, skills and experience to plan and manage HR, especially long-term Workforce Planning.</td>
<td></td>
<td>- Developing a 1-year action plan to put HR policy into practice;</td>
</tr>
<tr>
<td>There does not seem to be a functioning Human Resources Information System (HRIS) – only a basic payroll. SMOH has no Statistics Clerk.</td>
<td>Lack of resources to hire a Statistics Clerk.</td>
<td></td>
<td>- Developing and issuing job descriptions;</td>
</tr>
<tr>
<td>The organogram highlights the critical shortage of Human Resources in the SMOH office.</td>
<td>Lack of Job descriptions</td>
<td></td>
<td>- Orientation on staff management from the 2008 HR manual;</td>
</tr>
<tr>
<td>Further information is needed about the numbers and categories of staff working in the State* to define the real staff shortage across Jonglei.</td>
<td>Non-use of selection criteria for applicants to fill MOH vacancies (2008 HR Manual, p23)</td>
<td>*Recruit enough Clinical Officers to run the BPHS with a good salary to maintain them (to discourage them from going across the border (to Ethiopia, Kenya, Uganda) or joining NGOs.</td>
<td>- Regular visits to SMOH and CHDs;</td>
</tr>
<tr>
<td>The SMOH is currently downsizing staff. As Bor was formerly a garrison town, many people were given jobs during the war (e.g. SMOH had 100 cleaners). Since CPA these jobs were given to returnees but many are now being fired.</td>
<td>Lack of staff training plan (to upgrade qualifications or receive in-service training). Lack of selection criteria for training.</td>
<td></td>
<td>- Annual meetings for HR staff.</td>
</tr>
<tr>
<td>Although the 2008 HR Manual outlines most key staff management procedures, most are not being implemented (e.g. for recruitment, induction, job descriptions, line management, technical support, regular supportive supervision and performance appraisals, staff mentoring and training plans, grievance and discipline, termination, retirement, etc). However, Bor CHD has been developing job descriptions and showed an example for a cleaner.</td>
<td></td>
<td></td>
<td>Strengthen the capacity of SMOH Human Resources Department to support the person responsible for Human Resources at County level (CMO?) through regular emails, visits, and meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Strengthen the capacity of MOH- GOSS HRD Directorate to develop a long-term Training Strategy to upgrade</td>
</tr>
</tbody>
</table>
Unqualified staff: A community midwife may be in post on a staff grade and salary due to a graduate. CHWs (especially relatives of Commissioners) are appointed as CMO.

"The Public Service Ethic is broken down. We need to instil the work ethic again".

*It was not possible to collect this information due to staff shortage and time constraints.
## HEALTH SERVICE DELIVERY

<table>
<thead>
<tr>
<th>Current scenario</th>
<th>Factors affecting performance</th>
<th>Needs identified/ *expressed</th>
<th>Priorities for capacity strengthening</th>
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<tbody>
<tr>
<td>The Basic Package of Health Services (BPHS) is not yet being implemented in Jonglei State. There is little awareness about the 2009 DPIIS policy document. (One CMO was using a 1998 document on PHC). At SMOH level, there is currently no Director for PHC in post (the former one resigned recently) or for Planning and M&amp;E.</td>
<td>Lack of staff at SMOH level to promote and supervise BPHS.</td>
<td>*Personnel in the SMOH and CHD offices to promote the BPHS policy.</td>
<td>Strengthen capacity of MOH-GOSS PHC Directorate to support SMOH PHC Departments through:</td>
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<td>The Lead Agency, IMA Worldwide, was appointed in late 2008 and will start raising awareness about BPHS and supporting NGOs to deliver services in 2 out of 11 counties (Akobo and Bor) in April. Although SMOH understand the vision of equitable coverage, current health service coverage is so low in Jonglei State. Some counties have no hospital; several are cut off for 6 to 9 months per year.</td>
<td>Lack of infrastructure (CH, PHCC, PHCU), qualified staff, finance, drugs and supplies, and appropriate transport for BPHS.</td>
<td>*Recruit enough Clinical Officers to run the BPHS. *Improve the flow of information about the BPHS and all the treatment guidelines.</td>
<td>- Developing a 1-year action plan to put BPHS policy into practice;</td>
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<td>There seems to be little priority given to encouraging community representation in the health system at Health Facility level, County or State level. There are no State or County Health Management Committees nowadays. Although some Village Health Committees exist, many of the Community Health Workers who used to work with them are now running facilities or offices instead of community health promotion activities.</td>
<td>Vast distances, swampy terrain, and poor road infrastructure contribute to challenges in planning service delivery, communication and supervision in Jonglei State.</td>
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<td>- Distributing BPHS documents and relevant treatment guidelines.</td>
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<td>The SMOH has continued to run some health services after NGOs left (e.g. a TB unit set up by CMA). It is too early to forecast whether and when the SMOH or CHD will be able to continue to sustain BPHS services after NGOs leave.</td>
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<td>- Developing and issuing job descriptions (in co-operation with HR Directorate);</td>
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<td>Map NGOs exit strategies and prepare for SMOH/CHD to take over.</td>
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<td>- Orientation on staff management from the 2008 HR manual;</td>
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<td>- Regular emails;</td>
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<td>- Regular visits to SMOH and CHDs</td>
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<td>- Annual meetings for PHC staff.</td>
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