POLICY BRIEF:

PRIORITY-SETTING OF HEALTH INTERVENTIONS IN THE CONTEXT OF THE HEALTH POOLED FUND IN SOUTH SUDAN

The priority-setting process in the context of the Health Pooled Fund (HPF) is challenged by data limitations, minimal stewardship of the Ministry of Health (MoH) and competing interests among donors, HPF management, MoH, local authorities and implementing partners. Realities on the ground, such as conflict and a lack of human and financial resources, determine priority-setting and lead to differences in service provision across HPF implementing areas. South Sudan and the HPF could benefit from available tools and capacity development to make priority-setting more systematic, transparent, rational and fair.

PRIORITY-SETTING IN FRAGILE AND CONFLICT AFFECTED SETTINGS

In fragile and conflict-affected settings (FCAS) such as South Sudan where health needs are immense, financial resources are scarce, health infrastructure is rudimentary or damaged, and government stewardship is weak, adequate priority-setting of health services is especially important. However, the absence of systematic processes to guide decision-making, a lack of reliable information to inform decisions, and the presence of multiple actors with different interests[1] can severely complicate priority-setting. As a result, priority-setting tends to be ad hoc and materializes through a haphazard series of opaque choices,[2] leading to choices for health services and interventions that are insufficiently cost-effective and inadequately contributing towards health equity given the scarcity of resources. Despite the importance of adequate priority-setting in FCAS and the need to understand successes and challenges, there is a scarcity of research and documentation of priority-setting processes. Capturing these dynamics is important to develop more rational and fair priority-setting practices for FCAS and South Sudan in particular.

STUDY OBJECTIVE

A study was initiated to analyse the priority-setting occurring at the national and local level of the HPF3 program in South Sudan. A political economy analysis lens was taken to be able to explore the interests and ideas of stakeholders and the context in which the priority-setting takes place. The study is part of HPF's operational research agenda, currently being led by KIT Royal Tropical Institute (KIT), the operational research partner of the HPF consortium.

Box. 1: Definition of priority-setting[3]

The aim of the priority-setting process is to select among different options for addressing the most important health needs, given limited resources. The process of priority-setting is inherently political; it is a process where societal values and goals are important, and resulting priorities reflect a compromise among stakeholders, including the population.

APPROACH

The study used a mixed-methods approach combining document review, stakeholder interviews and a quantitative assessment of service delivery. The 30 stakeholders interviews were conducted between April and June 2020 and included staff from the HPF donors, national MoH, State MoHs, County Health Departments, HPF management team and implementing partners (IPs) (non-governmental organisations (NGOs)). Interview questions focused on the description of the priority-setting process for HPF programming and among IPs at the local level. Furthermore, the actual priorities set, the influence of stakeholders (i.e. their ideas and interests) and the context in which they operate were explored.

For the document review, key documents related to health policy in South Sudan and HPF programme documentation were reviewed to contextualise information received during the interviews. These included the Basic Package of Health and Nutrition Services (2011), the Health Sector Development Plan (2012-2016) the HPF3 Request for Proposals (2018), and HPF3 Business Case.

To gain more insight into priorities set at the local level by IPs, a quantitative assessment was done to compare differences in service provision across the HPF lots.[4] The 2019 Facility Service Register was used, which includes self-reported information on the availability of services at each facility. The Walt and Gilson policy triangle, a conceptual framework for political economy analysis, guided the data collection and analysis.[5]

SUMMARY OF FINDINGS

The context in which priorities were set

The HPF3 programme operates within a context of immense population health needs, a weak health system, and sustained turmoil. HPF3 is one of the main contributors to the health sector, together with international funding mechanisms with specific priority areas, such as UNICEF, Global Fund and UNFPA. Despite the development of key policy documents (e.g. Health Sector Development Plan 2012-2016, Draft National Health Sector Strategic Plan 2017-2022, National Health Policy 2015-2024 and a revised Basic Package of Health and Nutrition Services [2011]), the health sector remains highly dependent on external donors and technical assistance.

The observed priorities set at the national and local levels

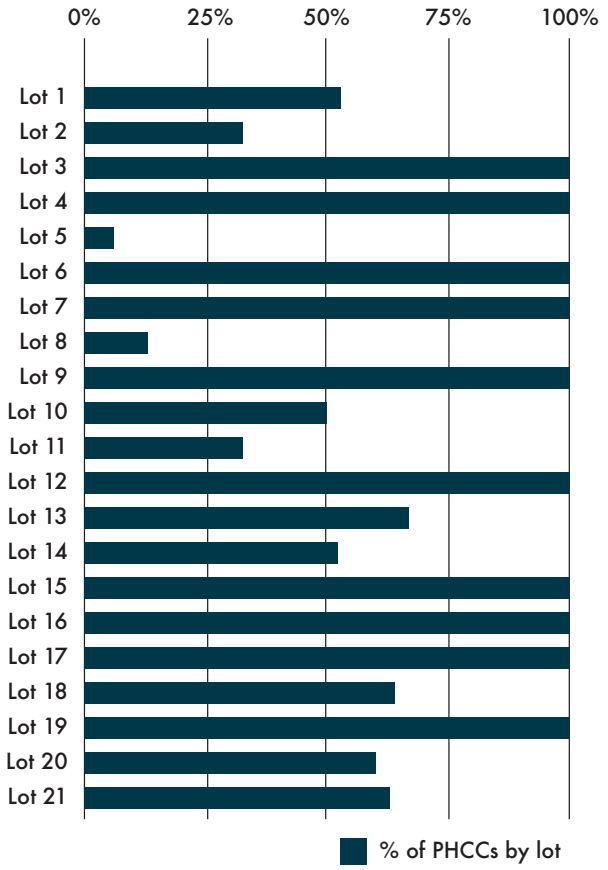
HPF3's stated aim is to support the Government of South Sudan in delivering the BPHNS through the provision of services through a network of health facilities and community-based systems. While HPF1 focused on *health systems building* in the post-independence period, HPF2 focused on *health system strengthening* and HPF3 on *health systems stabilization*. Within HPF3, explicit priority is given to the health of mothers, pregnant women and children under five, which is only part of the BPHNS that covers services across all disease areas. HPF3 prioritised funding for:

1. Boma Health Initiative (BHI) supporting community health workers and community engagement,
2. Gender Equality and Social Inclusion (GESI) supporting gender-based violence, clinical management of rape, family planning, and disability and mental health services
3. Immunization services.

Although these priorities are set for the entirety of HPF3's geographical coverage, implementation of these priorities vary across lots in terms of service provision. Figures 1 and 2 show the availability of sexual and gender-based violence services and skilled birth attendants at primary health care centres (PHCC).

Figure 1. Availability of skilled birth attendants at primary health care centres across lots

Figure 2. Availability of sexual and gender-based violence services at primary health care centres across lots



The implicit priority-setting processes

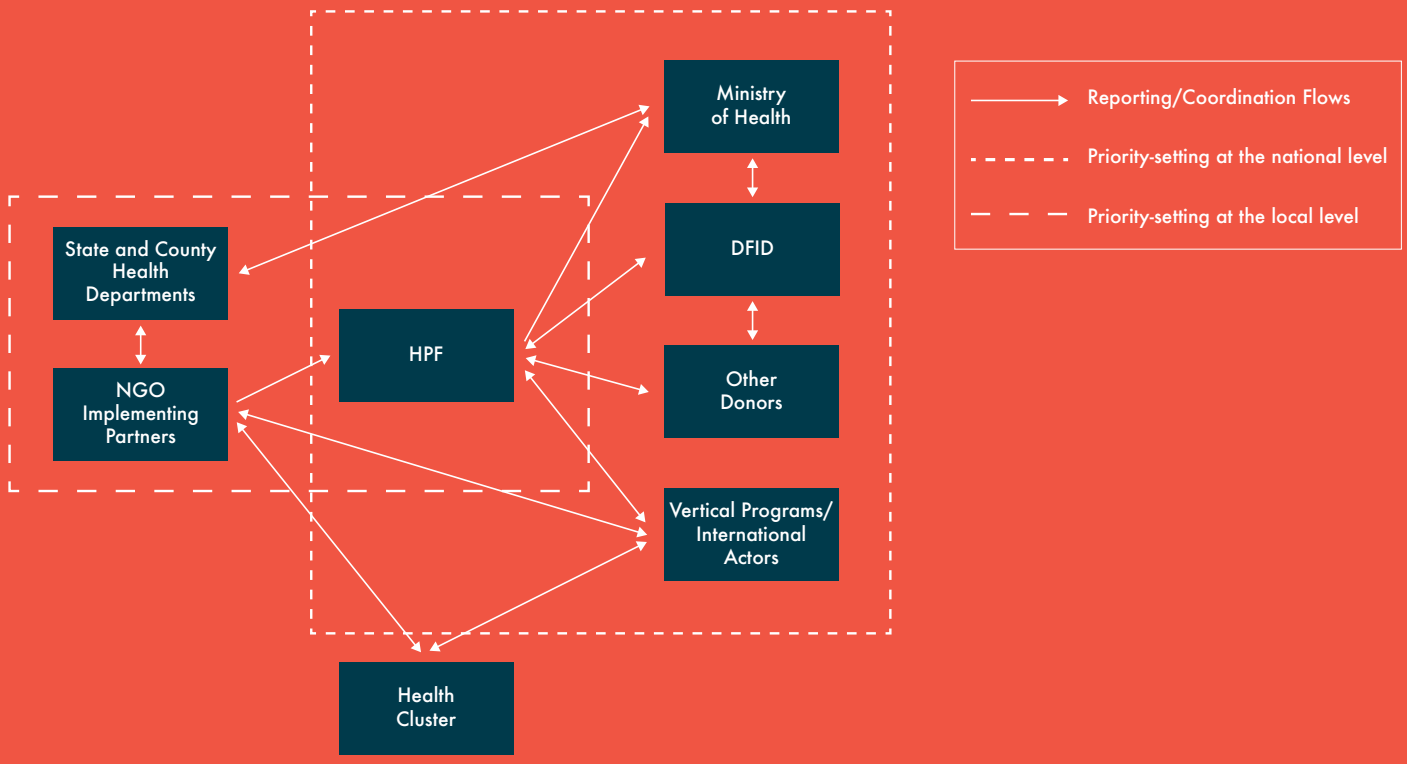
The use of the BPHNS for priority-setting of health services is limited and requires (re)negotiation, re-prioritisation and rationing to make it operational. This process appears to be unsystematic, opaque, at times implicit and dominated by particular interests at the national and local level.

At the national level, the priority-setting/planning phase spanned several months prior to HPF3. A business case was developed by the UK Department for International Development* (DFID), which favoured a Community Health focus over a Health Facility Infrastructure and National Health System Strengthening focus based on certain criteria: cost-effectiveness (cost per DALY saved), coverage, equity, and health system stabilisation. Following this, the process of specifically determining HPF3 programming occurred in a series of workshops among relevant stakeholders led by DFID. Broader consultative discussions occurred with the MoH and relevant external actors, including the World Health Organization (WHO), UNICEF, and the World Bank. In these meetings, the scope of work, including which services in the BPHNS were going to ensure HPF3's objectives and outputs, was discussed. Conversations occurred to explicitly remove components from programming by reviewing the activities of other partners and to reduce the number of facilities covered. It is unclear, however, how *prioritised* areas for programming were discussed, weighed, and compared, and whether this was completed in a systematic and rational way. HPF's priorities were set without the involvement of NGOs and local authorities that have knowledge of the immense lack of absorptive capacity on the ground, (i.e. shortage of skilled human resources for health on the ground).

The role of the BPHNS as a tool to inform these decisions is also ambiguous. While the importance of the BPHNS for programming was made clear, informant narratives also emphasised that priorities were set and then mirrored in the BPHNS to ensure congruence rather than determined by it. This highlights the weakness of the BPHNS as a technical document for priority-setting. Although the intention behind the BPHNS was to have an operational document containing prioritised primary and secondary health services for disease prevention and health promotion, in reality, it is a broad 'wishlist' of services with little connection to available resources and infrastructure. Over time, as additional components have been added, the basic package has become increasingly difficult to implement given local infrastructural and resource constraints.

Local-level priority-setting decisions were driven by trade-offs throughout the preparation and negotiation of the IPs' work plans. It was especially difficult to accommodate local level authorities priorities of the County Health Department (CHD), which were often at odds with HPF3 priorities. CHD priorities focused on ensuring high coverage of facilities, renovations, and salary payments, all of which were not priority-areas for HPF3. Furthermore, IPs had substantial technical requirements from HPF and a limited budget to implement them. IPs had to carefully decide how to meet these technical requirements while also maintaining buy-in from local authorities. The decisions IPs made to manage these competing expectations ultimately influenced HPF activity at the lot level. Furthermore, IPs make implicit decisions in implementation due to resource constraints, including access to skilled health workers and adequate health facility infrastructure.

Figure 3. Overview of actors involved in HPF priority-setting



*DFID was replaced by the Foreign, Commonwealth & Development Office, but is referred to as DFID here as the analysis was done retrospectively.

Figure 3 shows the actors involved in the HPF programme. As contributors of financial and technical resources to HPF, DFID (in consultation with the other donors) leads priority-setting at the national level and maintains leverage over this process. While the MoH is another primary actor, the contracting mechanism through which HPF is structured keeps funding outside of the government system. As a result, it is apparent that a mechanism is lacking, to ensure adequate engagement of national authorities, beyond the formal partnership structuring HPF.

Furthermore, when examining the ideas and interests held by the actors involved in HPF, divergences in certain ideas and interests were observed. Although a common commitment to public health in South Sudan is shared, donors are also bound by the health priorities set by their own constituents and have particular interest areas where they expect to see results. The MoH on the other hand sees HPF as a government initiative implementing the national BPHNS. National and local interests also diverge. While local authorities' interests are focused on strengthening local health infrastructure and governance through full coverage of facilities and support for renovations, infrastructure, training, and capacity development, this is not a priority area for HPF3. These divergences in the conceptions of the role of HPF nationally and locally indicate the absence of a shared understanding of the different ideas and values among actors. This shared understanding is needed to ensure fully participatory, fair, and transparent decision-making processes.

RECOMMENDATIONS

The WHO and scholars have developed guidelines and tools to improve priority-setting processes in health.[6] These are based on a common understanding that a priority-setting process should be rational, participatory and transparent. Figure 4 provides more details on these elements. The rationale behind focusing on elements of the *process* is because it is difficult to assess when certain decisions are fair. However, it can be assumed that when the process of decision-making has been agreed upon, the outcomes of such a process, the ultimate decisions will be fair.

At the moment there are no international guidelines for priority-setting specifically in FCAS or in the context of a multi-donor fund. The application of available guidelines and tools is more difficult in FCAS due to limited availability of data, weak capacity of governments to lead the processes, and limited knowledge among stakeholders on the principles of priority-setting in health. Flexibility should therefore be allowed. For example, when (scientific) evidence and data about the most urgent health issues and the impact of interventions is scarce, experts and stakeholders can be consulted as a second-best option. Improving priority-setting processes cannot be done overnight and should be done gradually.

Figure 4. Elements for a priority-setting process based on international guidelines

RATIONAL

- **Evidence** should inform the priority setting process. This includes a situational analysis of the most important health needs and health system capacity. Evidence should be collected on the value (so called performance) of interventions* in order to compare and assess the different options.
- **Criteria** such as cost-effectiveness, equity, health systems feasibility and political acceptability should be used to set priorities. These criteria should reflect the values and interests of stakeholders.

PARTICIPATORY

- All relevant **stakeholders** should be identified and participate in the priority setting process. The **values** and **interests** of stakeholders should be identified.
- Tools should be used to **reach consensus** among stakeholders.

TRANSPARENT

- **Steps** of the priority setting process should be defined and published for stakeholders.
- The **outcomes** of the priority setting process should be documented and published for stakeholders.
- **Appeal mechanisms** should be installed so stakeholders can challenge decisions.

** Intervention is a broad term, and this includes programme activities and actions*

The study presented in this brief has shown that priority-setting in HPF takes place at various levels:

1. In the design of the BPHNS, a key reference document for the HPF3 programme
2. In the programme design of HPF3 where the programme objectives and service package is defined,
3. In the contracting process of the IPs (both in the proposal writing process and the work plan/budget negotiations). Furthermore, the IPs set priorities throughout implementation when confronted by realities on the ground.

The following recommendations provide ideas on how priority-setting can be further improved at these levels, in line with the elements of Figure 4. Although several elements are already present in the context of HPF, such as the involvement of stakeholders and the use of evidence, the key is to do it more systematically and transparently.

Support the revision of the BPHNS to make it more realistic

In order to set more realistic priorities, the BPHNS should be revised in line with resources that can realistically be expected for its implementation. Available tools for priority-setting can be used to guide such a process in order to make it more rational, participatory and transparent.[7,8] South Sudan can learn from other countries such as Afghanistan that have been able to revise and define a realistic package of services that is now being implemented by contracted NGOs. Another example is Ethiopia that is revising its package and taking into account the available budget for implementation. Visitations for knowledge exchange can be organised with other countries in the region to share lessons learned.[9]

Develop priority-setting tools to support IPs

IPs should be supported to improve their priority-setting processes in the lots where they work. This can be done in several ways. In the proposal phase, a **situational analysis**[10] can be done in a more systematic way, which includes the health needs, health system capacity and other contextual factors that influence programming in a particular lot. **Criteria for priority-setting** of programme interventions and activities can be made more explicit. In the project proposal phase as well as during implementation, criteria can be made explicit that explain why actual implementation differed from the work plans. A comparison between the budget and actual expenses for services can be a basis for this. The identification of criteria can be supported by the use of **criteria map**.[11] Tools for **stakeholder analysis and participation**[12] can be provided to IPs so that the involvement of stakeholders is similar across all lots, during both in the proposal writing phase and programme implementation. Special attention can be given to how to adequately involve local health authorities and programme beneficiaries. Furthermore, IPs can be supported in the **systematic assessment of the interventions** options using a **performance matrix tool**.[13] This matrix presents the different interventions or decision options, the criteria to set priorities and which interventions provide the most value based on these criteria (Figure 4). This tool also provides guidance for a deliberative process. To **increase transparency** about the priorities set during HPF programme implementation, IPs should be asked to include a short narrative that explains the priorities set and the criteria used for this in their regular reporting to HPF.

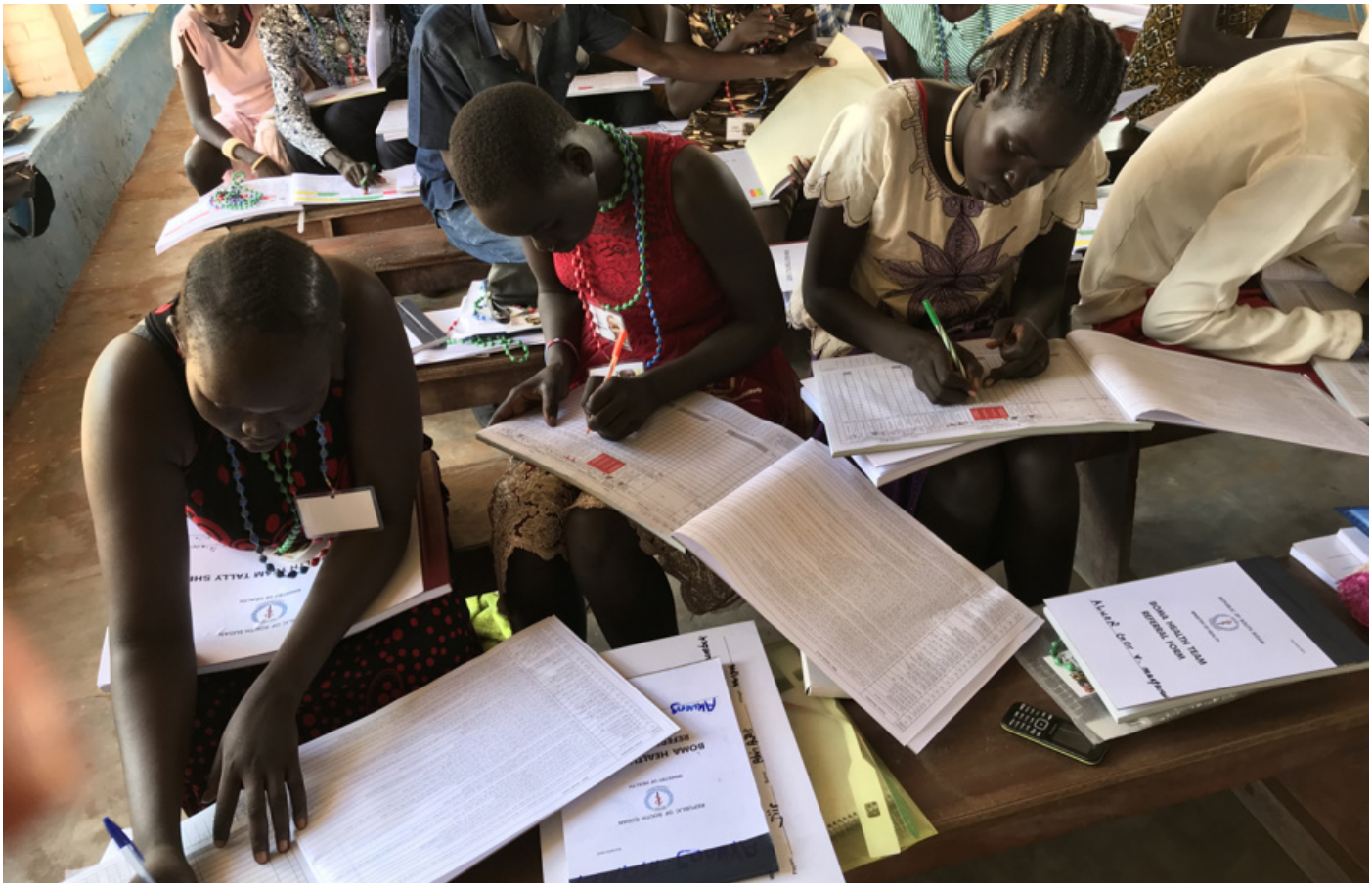
Develop an explicit priority-setting process for the next phase of the HPF programme design

An explicit priority-setting process can be designed for the next phase of the HPF programme, using the available tools from WHO and scholars. Box 2 shows the steps for such a process, as suggested by the WHO.[14] While the study demonstrated that most steps were already taken in HPF3, it could be made more explicit and transparent. For example, tools could be used to ensure that all relevant stakeholders participate in the process and that consensus is reached among them. Furthermore, the criteria could be made more explicit, and the service package intervention options could be compared using a performance matrix. To increase transparency, the entire process should be documented and published to all stakeholders.

Table 1. Example of a priority-setting matrix showing the performance of different interventions options for several selected criteria for priority-setting

Options	Cost-Effectiveness	Severity of Disease	Disease of the Poor	Age
Antiretroviral treatment in HIV/AIDS	US$200 per DALY	• • • •	✓	15 years and older
Treatment of childhood pneumonia	US$20 per DALY	• • • •	✓	0-14 years
Inpatient care for acute schizophrenia	US$2000 per DALY	• •		15 years and older
Plastering for simple fractures	US$50 per DALY	•		all

A tick indicates the presence of a feature. Severity of disease is shown on a four-star scale, with more stars indicating a more severe disease.



Support the establishment of a health technology assessment unit

Understanding of the principles of priority-setting in health among stakeholders is crucial to improve priority-setting processes.[15,16,17] In many countries, this capacity is institutionalised in so-called *Health Technology Assessment* agencies, independent bodies that provide technical assistance to government actors in the setup and implementation of priority-setting processes. In the context of South Sudan, a first step could be the establishment of a health technology assessment (HTA) unit within the MoH or externally led by a university or NGO. This unit can lead the roll-out of a situational analysis, collect evidence on the performance of interventions in terms of cost-effectiveness, health systems constraints, and health equity, and support the revision of the BPHNS. To initiate this, HPF and the MoH can collaborate with the International Decision Support Initiative (iDSI),[18] a global network of research institutions, non-governmental organisations and HTA institutions that supports countries to make better decisions and increase the value and impact of health spending.

CONCLUSIONS

The priority-setting process in the context of HPF is characterised by a scarcity of documentation, limited use of data and the strong influence of power asymmetries between donors, HPF management and the MoH. Priority-setting in South Sudan could benefit from the use of systematic processes and available tools in order to increase the fairness of decisions.

Box 2. Steps for a priority-setting process suggested by the WHO

1. Adopt a clear mandate for the priority-setting exercise.
2. Define the scope of the priority-setting and who will play what role.
3. Establish a steering body and a process management group.
4. Decide on approach, methods and tools.
5. Develop a work plan/roadmap and assure availability of the necessary resources.
6. Develop an effective communication strategy.
7. Inform the public about the priority-setting and engage internal/external stakeholders.
8. Organise the data collection, analysis and consultation/deliberation processes.
9. Develop or adopt a scoring system.
10. Adopt a plan for monitoring and evaluating the priority-setting exercise.
11. Collate and analyse the scores.
12. Present the provisional results for discussion; adjust if necessary.
13. Distribute the priority list to stakeholders.
14. Assure the formal validation of recommendations of the priority-setting outcome.
15. Plan and organise the follow-up of the priority-setting, i.e. the decision-making steps.
16. Evaluate the priority-setting exercise.

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