Joint Assessment of National Health Strategies (JANS)

Lessons from the JANS on Sudan's National Health Sector Strategic Plan

Lessons learned paper prepared for the International Health Partnership+

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Executive Summary: Lessons from the JANS on Sudan's National Health Strategic Plan

Joint Assessment of National Health Strategies and Plans (JANS) is a shared approach to assessing the strengths and weaknesses of a national health strategy, that is accepted by multiple stakeholders, and might be used as the basis for technical and financial support. This report on the JANS in Sudan identifies lessons about the JANS process: how it functions, what difference it makes and whether the objectives are likely to be met. The Joint Assessment was carried out in November 2012 on Sudan's National Health Sector Strategic Plan 2012-16 (NHSSP). This was the first JANS to be a "One JANS", i.e. giving special attention to the alignment of the strategies/plans of the various major technical programs (particularly those funded by the Global Fund and GAVI) with the overall national Strategy.

The work for this report was carried out in June 2013. It involved face-to-face and telephone interviews, plus a review of relevant documentation.

The report identifies 10 "lessons learned" from the JANS process in Sudan.

1. **The idea of "One JANS" makes sense and is feasible.** In Sudan, the overall process of the "One JANS" was highly significant, as it made many officials realise the extent to which the vertical programmes had similar parallel systems for activities such as training, procurement, logistics, outreach, health promotion, laboratories, supervision and monitoring. "One JANS" is not, however, a complete replacement for detailed reviews of programme strategies, which can focus more on technical details.

2. **An appropriately timed pre-JANS can be very helpful.** The pre-JANS for Sudan was very valuable because it pointed out key areas that needed attention in the draft NHSSP, notably costing and monitoring.

3. **The objectives of a JANS need to be carefully and realistically adapted to the national context.** The objectives in Sudan - national ownership, improved quality of the strategy, reduced transaction costs and improved confidence of partners to ensure more predictable and aligned funding – were fairly typical of a JANS. What was not typical, however, was the international position of Sudan, with sanctions and many governments not channeling funds through the government for political reasons. In this context, "more predictable and aligned funding" was not really a realistic short-term objective, even though some partners did say that the draft NHSSP had, to some extent, improved their confidence in the Ministry of Health.

4. **The JANS assesses national strategies against a global "gold standard" of an ideal strategy.** The Ministry of Health and other stakeholders should understand this in advance so that they are not unduly disappointed when there are many challenging recommendations.

5. **The JANS tool is generic and can be used in federal countries.** However, a JANS in a federation will look a bit different because it has to respond to the fact that health is generally a devolved, state-level responsibility.

6. **The whole process of developing a JANS-ready draft strategy can have important consequences which are not captured in the JANS report.** The JANS report follows a set template and does not systematically document the effects of developing a national strategy. In Sudan, for example, the situation analysis, which stated that 40% of the population did not have access to primary health care, had a profound effect: many interviewees said that they had not realised the figure was so high.

7. **The One Health costing tool is potentially very valuable, though there are some practical problems that need to be ironed out**.

8. **Careful selection of the JANS team is important so that the team is well balanced in terms of skills, experience and nationality.** The team in Sudan had seven members, which was generally felt to be a good size. One team member covered the four main technical programmes (immunisation, HIV/AIDS, tuberculosis and malaria). However, it was felt that other countries should not take this as the norm – the range of expertise of the particular individual may be difficult to find in another person and it may be that two JANS team members are required to assess technical programmes for a "One JANS". The size of the team also obviously depends on how many technical programmes the JANS will focus on.

9. **Think carefully about the timing of the JANS: no timing is perfect, but it is an important issue.** In Sudan, a complete and mature draft was assessed: this is preferable to a JANS which is done at too early a stage. On the other hand, the whole process of finalising the NHSSP was very delayed, given that the strategy covered the five-year period beginning January 2012.

10. **The period after the JANS report is very important: there need to be specific plans to finalise the strategic document.** In Sudan, there was a long delay between the JANS report and finalising the strategy. It is easy to lose momentum after a JANS, and it is a time when key staff may be transferred because the drafting of the strategy might be seen as completed. As part of the pre-JANS sensitisation, Ministries should be asked to allow for a period of, say, 6 weeks, when staff who have worked on the draft are given the time and encouragement to respond to the JANS recommendations and finish the strategy.

The Ministry of Health also asked for recommendations specific to Sudan to complement the international focus of most of the lessons learned. For Sudan, the recommendations are:

1. Keep up the positive momentum for the entire planning cycle. Organise a **Mid-Term Review** (MTR) and an independent **evaluation**.
2. Plan the **governance** of the MTR and evaluation: one option would be to extend the work of the JANS Organizing Committee.
3. Continue to strengthen the **annual plans** in States and programmes. Clearly show the links with the NHSSP in terms of focussing on the same priorities.
4. Work with the Ministry of Finance as it develops and implements the **Aid Co-ordination Strategy**, which aims to bring humanitarian and development funding closer together.
5. The Ministry of Health **Compact** should include some modest but important short-term milestones (e.g. to improve the alignment of existing support).

6. Use the opportunities of **GAVI and Global Fund applications** to demonstrate good practice in terms of how technical programmes can work in a more integrated way.
7. Continue work on **costs**; by the time of the next strategic plan, the Ministry should have a good idea of its overall cost patterns.

Acknowledgements

I am very grateful to all those who responded to questions and for the assistance from the Ministry of Health and WHO in arranging interviews and logistics. Particular thanks to Dr. Abdalla Sid Ahmed Osman, my co-consultant, who was an informative, helpful and engaging colleague.

Acronyms

cMYP	Comprehensive Multi-Year Plan (for immunisation)
EPI	Expanded Programme on Immunization
FMA	Financial Management Assessment
HSS	Health Systems Strengthening
IHP+	International Health Partnership
IRC	Independent Review Committee (GAVI)
JANS	Joint Assessment of National Strategies and Plans
M&E	Monitoring and evaluation
MOH	Ministry of Health
MTR	Mid-Term Review
NHSSP	National Health Sector Strategic Plan
WHO	World Health Organisation

Introduction

Sudan has a National Long-term Strategic Plan for the 25-year period 2007-2031. The National Health Sector Strategic Plan 2012-16 (NHSSP) is the second five-year health plan that is aligned with this overarching Strategy.

In November 2012, a Joint Assessment of the draft NHSSP was conducted; the report was finalised in January 2013.[1] This paper draws together lessons from the JANS and subsequent developments up to May 2013. [Joint Assessment of National Health Strategies and Plans (JANS) is a shared approach to assessing the strengths and weaknesses of a national health strategy, that is accepted by multiple stakeholders, and might be used as the basis for technical and financial support.]

1. TOR and methodology: learning lessons from the Sudan JANS

This report on the Sudanese JANS aims to identify lessons about the JANS process: how it functions, what difference it makes and whether the objectives are likely to be met. This is one of a series of follow-ups of JANS experiences: similar exercises have been carried out in Nepal, Ethiopia, Uganda, Ghana, Kyrgyzstan, Rwanda and Vietnam. The format of this report is broadly similar to that of previous reports. Terms of Reference are given in Annex 1. This report does not discuss what should happen next in terms of the NHSSP in Sudan and its implementation.

In contrast with the follow-ups of JANS in other countries, the Sudan lesson-learning exercise was conducted some time after the JANS mission. The author visited Sudan for four days in May/June 2013, five months after the JANS mission. Working with a local consultant Dr Abdalla Sid Ahmed Osman, she met with His Excellency the Federal Minister of Health, other stakeholders from the Ministries of Health and Finance, the National Assembly, National Council of Strategic Planning, National Health Insurance Fund, development partners and NGOs, as well as with the two Sudanese members of the JANS team. Group meetings were held with the JANS Organizing Committee and the NHSSP Development Team. The author also interviewed most of the team members not based in Sudan by telephone; the consultant who had supported the finalisation of the draft Strategy; and GAVI and the Global Fund. A list of interviewees is given in Annex 2. A review of relevant documentation was also undertaken.

This was the first JANS to be a "One JANS", i.e. giving special attention to the alignment of the strategies/plans of the various major technical programs (particularly those funded by the Global Fund and GAVI) with the overall national Strategy. The idea of "One JANS" emerged from observations in other countries that Joint Assessments were being carried out not only of the overall national health strategy, but also – separately – of the strategies of individual technical programmes. This was time-consuming for Ministries of Health and rather missed the point of the overall JANS, because the separate pieces of work did not always consider the consistency of the disease strategies with the overall national strategy.

[1] *Joint Assessment of Sudan's National Health Sector Strategic Plan 2012-16* by Chabot et al., January 2013. http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Key_Issues/NHP___JANS/Sudan%20JANS%20Report.Jan%202013.pdf. This report draws heavily on this reference.

During the initial briefing about this lesson-learning exercise, the Ministry of Health asked for one additional question to be added to the Terms of Reference: *Where do the "seven behaviours" of development partners fit in and how do we monitor if this is happening?* The question refers to a number of critical areas where international development partners need to change their behaviour in order to accelerate progress on the MDGs: the areas (branded as "The Seven Behaviours") were identified by participants at a global International Health Partnership (IHP+) meeting in December 2012.[2] The response to this question is given in Box 3. Later, the Ministry also asked for country-specific recommendations; again, these are included in Box 3.

2. The NHSSP and the JANS: description of the processes

2.1 Context - development of Sudan's National Health Sector Strategic Plan

The development of the NHSSP was highly participatory, in terms of both involvement in plan development and consultations about the content of the plan. An NHSSP Development Committee and seven Technical Working Groups reported to a Steering Committee, which included senior Ministry of Health (MOH) staff and UN officials. There was also an Advisory Committee with membership from MOH departments, relevant UN agencies and others sectors. Although these committees meant that a broad range of people were involved with the development of the NHSSP, there were some problems. Membership of the Development (NHSSP writing) Committee changed several times, meaning that there were problems with continuity.

The process began in February 2011 with the establishment of the various groups and committees and agreement about the methodology for developing the NHSSP. The following month there was a workshop with the MOHs from the States to agree on the overall priorities for the NHSSP. During the rest of 2011, there were more than 100 meetings to discuss the NHSSP, the majority of which were the Technical Working Groups. Key events are shown in Box 1.[3] This level of involvement and consultation was unprecedented in Sudan: the development of the previous five-year NHSSP had been a much more technocratic process. That said, participation in the process was at times disappointing: some development partners for example did not engage. One JANS team member commented on the "aloofness" of several significant development partners from the NHSSP and JANS.

Sudan is a federal country, so the involvement of the States was crucial. In addition to the March 2011 workshop mentioned above, States were involved in many stages of the development of NHSSP including a meeting after the pre-JANS mission to discuss its findings and the opportunity for every State to comment on the draft NHSSP.

At the time of this author's visit to Sudan (early June 2013) the NHSSP document had still not been completed, although a Task Force had been established with a roadmap. In the first half of 2013, however, there had been a significant re-structuring of the Ministry of Health, bringing together the various technical programmes into one directorate. This was

[2] http://www.internationalhealthpartnership.net/en/news-events/article/seven-behaviours-how-development-partners-can-change-for-the-better-325359/

[3] This section refers extensively to the PowerPoint presentation *Sudan NHSSP 2012-16, Development Methodology and Process* prepared by Dr. Zahir Ajab Alsiddeig of the MOH.

seen as a vital step in implementing the NHSSP and taking forward one of the main points raised by the JANS – co-ordination amongst technical programmes and links with the overall health strategy.

The pattern of annual plans based on the five-year Strategy was able to continue even when the NHSSP was in draft form, which meant that there was not an overwhelming pressure within the Ministry to prioritise finalising the NHSSP. This 'continuing-as-usual' approach begs the question of when the nature of the annual plans should fundamentally change to be more horizontally and vertically co-ordinated. The importance of this co-ordination across programmes and with States is highlighted in both the NHSSP itself and in the JANS report.

The NHSSP was finished in July 2013 and presented to a stakeholder workshop.

Box 1. Key events in the development of the NHSSP

- February 2011: Formulation of committees and agreement on the methodology for developing the NHSSP
- March 2011: Workshop with the Ministries of Health in States to agree on the main directions of the NHSSP
- February 2012: Presentation of draft NHSSP to the Under-Secretary Council, followed by further work on the draft
- May 2012: Pre-JANS conducted by IHP+ (International Health Partnership)
- May 2012: meetings of health development partners; Parliamentary Population and Health Committee; national and international NGOs.
- June-November 2012:
    - finalising draft with a focus on addressing pre-JANS findings (costing and M&E). Two visits from international consultant supporting the finalisation.
    - Meeting of States' Ministries of Health to discuss NHSSP draft and States' Health Strategies
    - JANS Organizing Committee established
    - Health Minister's Advisory Council meeting
    - Under-Secretary Council meeting for approving the final draft
    - Development partners' meeting
    - Circulation of the draft strategy document for final comments from stakeholders
- November /December 2012: JANS mission and draft report
- December 2012: Draft JANS report shared with partners to provide comments and feedback. Partners' meeting to discuss report and prepare feedback. Detailed response to JANS report written.
- January 2013: final JANS report submitted.
- April 2013: Task Force established to complete the NHSSP.
- July 2013: NHSSP finished; stakeholder workshop for endorsement of finalized NHSSP.

2.2 The purpose of the Joint Assessment

A JANS is conducted using the Joint Assessment Tool and Guidelines.[4] The JANS tool examines the soundness and feasibility of a strategy in five areas:

1. **Situation analysis and programming:** clarity and relevance of priorities and strategies based on a sound situation analysis;
2. **Process:** soundness and inclusiveness of development and endorsement processes for the national strategy;
3. **Costs and budgetary framework for the strategy:** soundness and feasibility of the financial framework;
4. **Implementation and management:** soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy;
5. **Monitoring, evaluation and review:** soundness of review and evaluation mechanisms and how their results are used.

These five categories are further broken down into 16 attributes which are used to assess the draft national strategy.[5] To give one example, Attribute 14 is "Governance, accountability, management and co-ordination mechanisms for implementation are specified".

In general, the expected benefits of a joint assessment include enhanced quality of the national strategy and greater partner confidence in the strategy, thereby securing more predictable and better aligned funding. The objectives of the JANS in Sudan were clearly articulated:

- To ensure national ownership by facilitating strategic discussions;
- To enhance and improve the quality of the strategy;
- To improve confidence of partners to ensure more predictable and aligned funding;
- To reduce transaction costs.

The "confidence of partners" is a significant issue in Sudan: for a variety of reasons, including international sanctions, many multilateral and bilateral development agencies do not route money through the Government. The country, does, however receive grants from GAVI and the Global Fund. Infrastructure is, to some extent, funded by "non-traditional" donors such as China and Turkey.

The vast majority of international support to Sudan is for humanitarian, rather than development, purposes. The humanitarian/development split is a global issue which is often not discussed in the aid effectiveness literature. The Sudanese Government is developing an Aid Co-ordination Strategy, led by the Ministry of Finance, which aims to bring humanitarian and development funding closer together, with more involvement of federal and state ministries.

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[4] http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/

[5] See http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Tools/JANS/joint_assessment_tool_EN.pdf

2.3 Planning for the JANS

A pre-JANS took place in May 2012, consisting of technical people from the IHP+ Core Team (one from the World Bank, one from WHO). For the Ministry of Health, the objectives of the review were:

- To seek advice on the process and contents of the strategy;
- To sensitize and raise awareness amongst donors and other partners.

The pre-JANS was generally felt to be useful, as it highlighted areas which needed work before the JANS. The main recommendations were:

- The Strategy needed to be costed; use of the *One Health* Tool was suggested.
- The need for clarity and specificity about monitoring and evaluation (M&E).
- Details of the steps to be taken to finalise the strategy.

All the pre-JANS recommendations were accepted and acted on, resulting in the use of *One Health* for costing; technical support for M&E; and a consultant to support the overall finalisation of the plan.

There was some discussion about whether the pre-JANS could have gone into more detail. A draft NHSSP already existed, and more detailed feedback at that stage might have spread the work out better and made the JANS itself a somewhat less overwhelming process. One interviewee noted that timely feedback on the situation analysis would have been helpful – by the time of the JANS it was too late to make major changes. In other countries, the JANS tool has been used by the Ministry of Health before the JANS itself as a sort of “trial run”. But this is not what was meant in Sudan: the discussion there was about whether an *independent* review of an early draft would have been useful in the first half of 2012.

In general, different parties had different views about the pre-JANS mission. IHP+ saw it as an opportunity to ensure that all stakeholders were appropriately informed about the JANS process, whereas the Ministry was already interested in receiving feedback on its draft Strategy.

To prepare for the JANS, a JANS Organizing Committee was established, with members from the Federal MOH, development partners, national and international NGOs and the National Assembly Committee on Population and Health. The responsibilities of the team were to:

- Explain the JANS process and objectives to stakeholders;
- Agree on the JANS team members;
- Agree on the JANS objectives and time frame;
- Discuss the final report and the recommendations with the JANS team and the stakeholders.

Planning for the JANS was facilitated by WHO, and WHO in-country staff also participated in developing the draft strategy.

2.4 The JANS team

The Ministry of Health and JANS Organizing Committee were responsible for selecting suitable members of the JANS team, with active facilitation by the WHO Country Office and the IHP+ Core Team. The JANS team had seven members, all of whom were independent in terms of not being closely involved in developing the NHSSP. (This is the definition of independence set out in the JANS principles.) Team members are listed in Table 1. Most team members were funded by IHP+ or WHO; one was paid for by the Global Fund. The source of funding did not influence the role of individual team members: all were independent and selected because of their technical skills. No member represented any particular organisation.

Table 1. JANS Team Members, Sudan 2012

Name, nationality	Funded by	Expertise/role	Attribute Focus [6]
Dr Jarl Chabot, Netherlands	IHP+	Public health/health services, Team leader	1-4 and 14
Dr. Abebe Alebachew, Ethiopia	IHP+	Economist	8-9 and 13
Dr Bolanle O. Oyeledun, Nigeria	Global Fund (from a fund specifically for Technical Review Panel members)	Public health	5-7 and 13
Dr Colin Thunhurst, UK	IHP+	Epidemiology/public health; Monitoring and evaluation	15-16
Dr Grace Nyerwanire Murindwa, Uganda	IHP+	Public health	10-12
Professor Dr Mutamad Ahmed Amin, Sudan	WHO Sudan	Parasitologist	1-7
Professor Dr Zein ElAbdeen Abdul Rahim Karrar, Sudan	WHO Sudan	Pediatrician	1-7

In contrast to previous JANS, the team did not include a financial management expert and fiduciary issues were not reviewed in detail. This was the result of a global decision about the role of JANS: it is not a substitute for a fiduciary assessment by development partners planning to provide financial support.
One of the Sudanese consultants was very thoughtful about what being a JANS team member had meant for him. Some of his reflections are given in Box 2.

[6] This refers to the 16 attributes detailed in: http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Tools/JANS/joint_assessment_tool_EN.pdf

Box 2. The experience of being a national consultant in a JANS team

Because JANS team members should be independent, by definition the national consultants tend to be people who have not been closely involved in developing the national strategy. [This consultant was a professor of a clinical specialty.] It took me a while to decide whether I should accept the offer to join the JANS team: 10 days is a long time and I had to take holiday and give up all my normal jobs except signing documents.

The initial documents given to me to read before the mission were very intimidating – I'm more used to life as a clinician! For the first two days, I felt a bit lost. What was I supposed to do? But then it became clear: I could really add value (along with the other national consultant) by explaining the context and describing different viewpoints. It helped that the team leader was very clear about who should be doing what, and I enjoyed listening to experiences from other African countries. Another thing I liked was that every morning the team leader started with a briefing about what had been happening. This is important for local consultants because they tend to be staying at home, rather than in the "team hotel", and otherwise, we would miss out on the flavour of team discussions. I felt really involved in the report-writing process: that was good, too.

In the future, national consultants should be fully briefed about what is entailed: don't forget that a JANS mission is pretty intimidating for a national who probably doesn't know much about the national strategy. But I'm glad I did it. Moreover, I think it has improved my teaching, and look at all the up-to-date documents about Sudan I now have on my library shelves!

2.5 The Joint Assessment: Process and activities

From 18-30 November 2012 the JANS team reviewed the NHSSP using the combined Joint Assessment Tool and Guidelines (2011). Methods included:

- Review of documentation;
- Key informant interviews;
- Field visits to three states;
- A formal presentation and discussion with many of the State Ministers of Sudan's 17 states.

The IHP+ Secretariat deliberately did not produce detailed guidance about conducting "One JANS" (as opposed to a "straightforward JANS"). It was preferred to allow practical experience to precede and inform any such guidance. A preliminary two-page note was, however, prepared in 2012.[7]

[7] *Improving Synergy between a Health Sector Strategy and Programme Strategies. Doing a sector JANS with a more in-depth review of selected priorities: preliminary note on issues to consider.* May 2012.

2.6 Costs of the JANS

The additional costs for the JANS were essentially the costs for the JANS team consultants (funded by IHP+, WHO and the Global Fund, see Table 1) and logistical costs (including travel to States) borne by the Ministry of Health. There were also time costs for the Ministry and partners in setting up the JANS and meeting the team. The JANS mission and related activities were not part of existing governance structures, nor did they replace any other processes such as appraisals by development partners: the JANS was thus an additional transaction cost.

3. Assessment and lessons from the Joint Assessment

3.1 Views on the JANS process

Timing and duration

The duration and timing of the JANS were both generally felt to have been appropriate. The team was in Sudan for 13 days, with the technical programmes expert (Dr Oyeledun) there for a slightly shorter period. There was quite a lot of discussion about duration, but it was generally concluded that two weeks was a good balance between detail and practicality.

The timing of the JANS meant that a complete, well-developed draft was available for review, but that the final draft had not yet been politically endorsed. This was generally felt to be an appropriate time for a JANS.

The obvious *disadvantage* of the timing was that the JANS took place at the end of 2012, for a five-year strategy for the period January 2012 to December 2016. Clearly, this is far from ideal, though no-one in the Ministry of Health or National Council of Strategic Planning appeared to think that it was a particularly serious problem. It was generally argued that the draft was complete enough in practical terms for implementation to start, even without the final version of the document itself. The recent re-structuring of the Federal Ministry was given as an example of something happening that was a direct result of the draft strategy. (One interviewee said that re-structuring had been in the Ministry's mind for a while, but that the JANS report, in particular, confirmed its importance and the need to go ahead and do it.) A member of the National Assembly's Population and Health Committee said that Health would be the last Ministry to submit its strategic plan, but also that the NHSSP was one of the best line ministry strategic plans in Sudan. She said that a delayed final strategy was to a certain extent understandable and acceptable, given the high quality of the work, but that August 2013 was really an absolutely final deadline, as the NHSSP document needed to be finished by then to inform the budget deliberations for 2014. Development partners were the most troubled by the delay in finalising the NHSSP: the comment was made a number of times that the delay did not make a good impression in international circles.

The JANS team

The composition of the JANS team is shown in Table 1 above. It was generally felt that the composition of the team was good, with a reasonable balance of national, regional and global consultants. The team was seen as appropriate in skills and very competent.

One issue that caused considerable discussion was the role of Dr Oyeledun, the public health specialist charged with looking at the technical programmes. Unusually, Dr Oyeledun has served on both the Global Fund's Technical Review Panel and GAVI's Independent Review Committee. This meant that she was well qualified to look at all four of the main programmes: immunisation, HIV/AIDS, tuberculosis and malaria. Moreover, the four programme strategies had all been approved and politically endorsed and were already being implemented: they did not synchronise with the timeframe of the NHSSP (see Figure 1). This meant that Dr. Oyeledun did not need to assess "raw" drafts of strategies and she was able to assess all four programmes within the two weeks of the JANS. However, it was felt that other countries should not take this as the norm – Dr Oyeledun's range of expertise may be difficult to find in another person and it may be that more than one JANS team member is required to assess technical programmes for a "One JANS". Dr Oyeledun's own opinion was that the job of reviewing all the main technical programmes requires two people in the JANS team.

Figure 1. Disconnects between sector and programme planning cycles

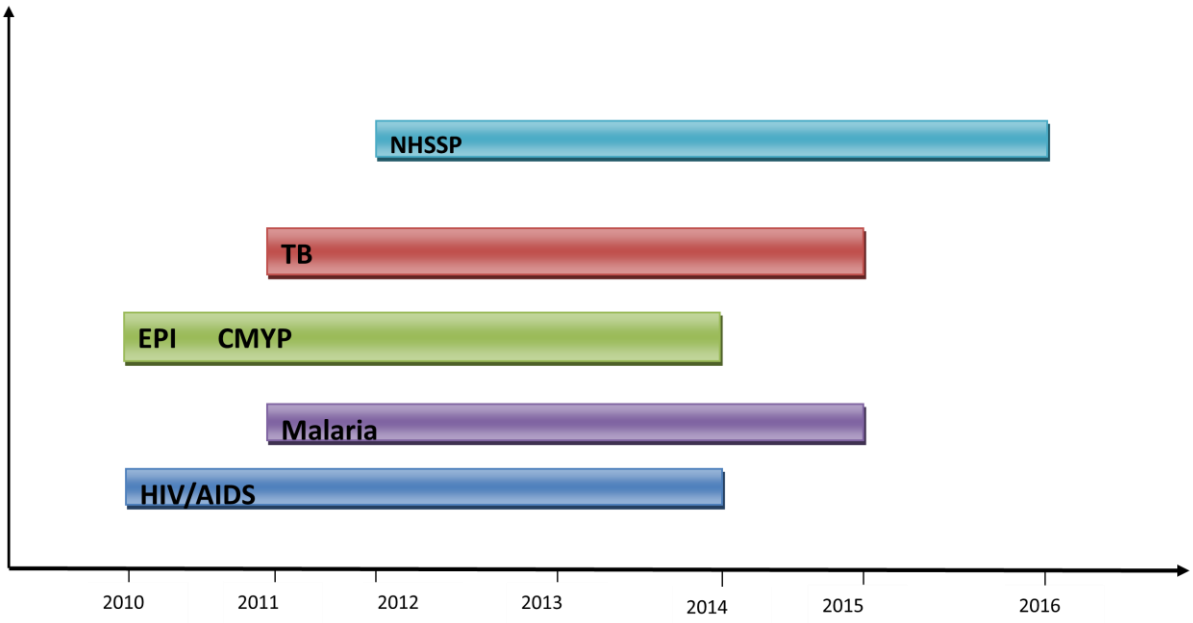

Figure taken from PowerPoint presentation by Dr. Imad El Din A M Ismail*: Assessing a sector strategy with an in-depth review of programme specific strategies - Sudan experience.*

3.2 Feedback on the JANS tool and guidelines

Stakeholders, in general, were positive about the JANS tool and guidelines. It was seen as useful to have a structured and comprehensive tool. In Sudan, the tool had helped to highlight the importance of integration, and the current inefficiency of multiple vertical systems for logistics, training, monitoring, etc. For the disease programmes, the system-wide assessment had really highlighted the many opportunities that are missed because of working separately. The JANS report documented and made explicit the disconnect between previous national planning processes and planning for the technical programmes.

The Ministry of Health did mention that more detailed guidelines about "One JANS" would help. (As explained in Section 2.5, the IHP+ Secretariat has plans to develop this.) The Ministry would have liked to have been clearer on which particular aspects of the programme strategies would be looked at alongside the NHSSP.

Another point was that although it was understood why there was no financial management expert on the JANS team (see Section 2.4), there was a desire for more clarity about the link between programmatic Financial Management Assessments (FMAs) and a sector-wide FMA.

Although not a criticism of the tool and guidelines, many interviewees mentioned how challenging Attribute 5 is ("Multi-stakeholder involvement in development of the national strategy and operational plans and multi-stakeholder endorsement of the final national strategy "). The private sector and NGOs are both very significant players in health in Sudan and both were involved in development of the NHSSP. However, neither grouping is set up to have meaningful representation of their constituency, so it was difficult to know how best to organise their participation, given that both involve multiple institutions. There was also an issue of capacity and motivation: for example, local NGOs were more accustomed to looking for funding opportunities than to advocacy. Despite these challenges, the involvement of private sector organisations and NGOs was a major step forward from the development of the previous five-year strategic plan. This issue of difficult-to-attain "gold standard" attributes is discussed again in Section 4 below.

UNAIDS had plans to use the JANS tool for a more detailed assessment of the HIV/AIDS strategy (as a complement to the overall One JANS). The idea was to use the attributes to look systematically at issues such as efficiency (would integrating some activities with other parts of the health sector be more efficient?) and implementation arrangements.

3.3 Feedback on the benefits and value of the JANS

The JANS findings were generally judged to be accurate and objective by the interviewees. The Ministry of Health co-ordinated a detailed response to the JANS report. The 34-page response provided many clarifications and asked for further explanation of some points from the report; it is notable, however, that only one of the almost 40 recommendations was rejected outright. This recommendation – about lobbying the Ministry of Finance for health centres to become cost centres – was not regarded as a "game-changer" by the JANS team.

One objective of the JANS was to give confidence to other development partners and lead them to consider funding the Government of Sudan for the health strategy. In general, it is unlikely that the development of the NHSSP and the related JANS will have much effect on

funding and how it is channeled. The two potential exceptions to this are domestic funding and the Global Fund. The JANS findings will also be used by GAVI.

The development of the NHSSP and the quality of the strategy seem to have had more impact domestically than internationally. Before the JANS, the Ministry of Health had already received a significant vote of confidence in terms of domestic resource allocation through the award of sizeable funding to the Primary Health Care Expansion Programme. (This type of funding was rare in the health sector.) Building on this positive precedent, the fact that a JANS took place added to the kudos of the NHSSP. What made a difference within Sudan was the robustness and relative inclusiveness of the strategy - and of course, these features of the NHSSP were partly down to the JANS process as a whole, from initial discussions to the final report. It remains to be seen whether this will be translated into actual increases in financial allocations to health in the 2014 budget.

> "The development of the NHSSP was a very convincing process. It was a good process and involved proper costing for the first time. It will surely help to mobilise local resources for the Ministry of Health budget."
>
> *Member of National Assembly*

The Global Fund regards the recommendations of the JANS as highly significant and has started a process of systematically reviewing them. The whole idea of a JANS is in keeping with the current Global Fund emphasis on bringing their grants together to make a more cohesive whole, with less duplication and better aligned to the overall national health strategy and its plans for health systems. The JANS report's strong emphasis on integration mirrors the Global Fund's focus on making its grants more efficient. In terms of Global Fund financing, the impact is likely to be in terms of *how* money is allocated, rather than the total *amount* of funding available. The allocation of Global Fund money will be influenced by the JANS in two main ways: in terms of the division amongst the three diseases and health systems and in terms of a shift away from funding surveillance, training, M&E, etc. for single diseases separately.

Reviews of specific disease strategies will still happen – these complement the "One JANS" because they delve more into important technical issues (for example, the appropriateness or otherwise of case detection methods in a TB strategy). In the case of HIV/AIDS, the scope of the strategy is different: the HIV/AIDS strategy should be multi-sectoral.

Although it probably will not lead to *more* money, the development of the NHSSP and the related JANS are a positive point in the Government's arguments for having the Ministry of Health as the Principal Recipient for more of the Global Fund's grants.

No other international funder (bilateral or multilateral) seems likely to change its mind about the amounts of funding for Sudan or the channels through which the money flows specifically as a result of the JANS. A large percentage of funding is still humanitarian - this is largely for political reasons beyond the sphere of influence of the health sector. Four development partners (three multilaterals, one bilateral) did, however, comment that the NHSSP was a positive step forward and enhanced their confidence in the Ministry by providing a much clearer framework within which development partners could broadly work. ("This gives a clear framework for our work in maternal and child health. We don't have to plan from scratch anymore.") One member of staff from a multilateral, who had been a member of the JANS Organizing Committee, commented that the process of strategy development had been a good one, with some interesting meetings and opportunities to comment on documents. Purely speculatively, the fact that the Ministry of Health has subjected its Strategy to the internationally recognised JANS process may, in the medium term, mean that health is a relatively attractive sector for funding from partners which support several sectors.

Sudan will apply for a new GAVI Health Systems Strengthening (HSS) grant in late 2013/early 2014. As part of its application, it will submit the NHSSP (which will have to have been completed) and probably also the JANS report. These documents will be used by GAVI's Independent Review Committee (IRC) to inform its decision about the application, though the main source of information will be the application form itself. It remains to be seen how having conducted a JANS will affect IRC decisions. In theory, if the application is clearly consistent with the NHSSP, the thoroughness of the JANS process should be in the application's favour.

GAVI HSS works with financial ceilings for individual countries, so the fact that a JANS has been conducted cannot influence the overall amount of money available to a country. Any effect would be in terms of issues such as the speed with which an application was approved and fully processed. Obviously, there could also be an influence on the decision about the proposal as a whole if the HSS proposal was clearly consistent with the NHSSP and the independent GAVI reviewers were influenced positively by the fact that a JANS had taken place.

The planning document for immunisation – the Comprehensive Multi-Year Plan, (cMYP) – also needs to be submitted as part of a GAVI HSS application. For its next HSS proposal, the Sudanese cMYP needs to be aligned in terms of timing with the NHSSP. In other words, a new cMYP needs to start in January 2017 at the same time as the next five-year national health strategy. Because of the One JANS and the way in which the NHSSP was developed, the importance of aligning technical programme strategies with the NHSSP is already well understood.

Sudanese interviewees differed in terms of what they thought about the objective of international resource mobilisation. Some were very disappointed by the lack of new funding possibilities; others saw the NHSSP and JANS as part of a long process and as positive contributions to the argument for more international funding channelled through the government.

The National Council of Strategic Planning had an interesting perspective on the NHSSP and JANS. Overall, they were very positive about the quality of the health strategy and the

inputs from the JANS. They did, however, regard the delays in finalising the NHSSP as an "inconvenience" – nothing stronger than that. (The Ministry of Finance said the same; both were familiar with the draft NHSSP.) The Planning Council's other concern was that the NHSSP did not fully fit into the national planning template, which requires annual milestones and indicators that are about 30% input, 40% output and 30% outcome indicators. For the Council, the monitoring framework in the NHSSP was "donor-style, not National Council-style". This was also an issue for the National Assembly, because it relies on annual indicators to inform its budgeting. In general, however, the National Council was pragmatic: the JANS process contributed positively to the quality of planning in the Ministry of Health and this was regarded as a good thing.

4. Lessons learned

1. **The idea of "One JANS" makes sense and is feasible.** Respondents felt that it was obvious and natural that a JANS should look at the relationship between the overall national strategy and the more detailed programme strategies: "One JANS" should be the norm for any JANS. In Sudan, the overall process of the "One JANS" was highly significant, as it made many officials realise the extent to which the vertical programmes had similar parallel systems for activities such as training, procurement, logistics, outreach, health promotion, laboratories, supervision and monitoring. "One JANS" is not, however, a complete replacement for detailed reviews of programme strategies, which can focus more on technical details. It may be necessary to prioritise which programmes "One JANS" focuses on, as some countries have a large number of technical programmes.

2. **An appropriately timed pre-JANS can be very helpful.** The pre-JANS for Sudan was very valuable because it pointed out key areas that needed attention in the draft NHSSP, notably, costing and monitoring. After the pre-JANS it took almost six months for the draft strategy to be ready for the JANS. It is important that the Ministry and IHP+ are clear about the objectives of the pre-JANS.

3. **The objectives of a JANS need to be carefully and realistically adapted to the national context**. The objectives in Sudan – national ownership, improved quality of the strategy, reduced transaction costs and improved confidence of partners to ensure more predictable and aligned funding – were fairly typical of a JANS. What is not typical, however, is the international position of Sudan, with sanctions and many governments not channeling funds through the government for political reasons. In this context, "more predictable and aligned funding" was not really a realistic short-term objective, even though some partners did say that the draft NHSSP had to some extent improved their confidence in the Ministry of Health. It seems unlikely that there will be many immediate benefits to Sudan in terms of more aligned, predictable funding (with the exception of shifts in Global Fund allocations and perhaps some improved alignment of existing funds from other partners), and this is inevitably disheartening to those who worked very hard on developing the draft strategy and preparing for the JANS.[8] In the longer term,

[8] During the JANS in Sudan, the team leader stressed several times that the JANS was no guarantee of additional funding. Even so, expectations had already been raised and there was disappointment.

however, there may be benefits to the Ministry from taking this initial step of improving partner confidence by undergoing the JANS.

4. **The JANS assesses national strategies against a global "gold standard" of an ideal strategy: Ministry of Health and other stakeholders should understand this in advance so that they are not unduly disappointed when there are many challenging recommendations.** JANS reports are likely to specify many weaknesses, even for high quality strategies - that is the nature of the JANS report format and in the spirit of improving draft strategies. But this process can be demoralising, especially given the amount of hard work that goes into developing draft strategies. The "gold standard" should not be compromised; but it would be useful to explicitly discuss this with stakeholders *before* the JANS, so that there are not unrealistic hopes for an overwhelmingly positive JANS report. In Sudan, the JANS report recommendations were generally regarded as fair and constructive. Even so, respondents also described the impact of the many recommendations as "overwhelming", "discouraging" and "fatiguing".

5. **The JANS tool is generic and can be used in federal countries. However, a JANS in a federation will look a bit different** because it has to respond to the fact that health is generally a devolved, state-level responsibility. Some of the JANS team members should have experience of federal countries, and the briefing needs to reflect the importance of federalism.

6. **The whole process of developing a JANS-ready draft strategy can have important consequences which are not captured in the JANS report.** The JANS report follows a set template and does not systematically document the effects of developing a national strategy. In Sudan, the situation analysis, which stated that 40% of the population did not have access to primary health care, had a profound effect: many interviewees said that they had not realised the figure was so high. Other positive changes brought about by the process of strategy development were the experience of involving the National Assembly, NGOs and the private sector; the systematic use of existing data such as the census and National Health Accounts; a realisation of the need to synchronise the national and programmatic strategies in terms of planning periods; and an understanding of the extent to which vertical programmes duplicated efforts in areas such as surveillance, training and supervision.

> "I really learned a lot from the NHSSP's situation analysis. Maternal and child health really is the priority for Sudan, even though I come from a different technical part of the Ministry."
>
> *MoH official*

7. **The One Health costing tool is potentially very valuable, though there are some practical problems that need to be ironed out**. Respondents were generally very positive about the One Health tool, particularly about how the costing exercise highlighted duplication amongst technical programmes in areas such as monitoring and logistics. There were some practical problems – for example, needing to refer problems back to operators outside Sudan and not enough emphasis on overall hospital costs – but these can be dealt with as the tool is used more. Thought needs to be given to how much detail is required; the Sudan costing at times became swamped by unnecessary details. The tool also needs to have closer links to budgeting, so that it becomes a practical planning/implementation exercise, rather than its current somewhat academic focus.

8. **Careful selection of the JANS team is important so that the team is well balanced in terms of skills, experience and nationality.** The team in Sudan had seven members, which was generally felt to be a good size. One team member covered the four main technical programmes (immunisation, HIV/AIDS, tuberculosis and malaria). However it was felt that other countries should not take this as the norm – the range of expertise of the particular individual may be difficult to find in another person and it may be that two JANS team members are required to assess technical programmes for a "One JANS". The size of the team also obviously depends on how many technical programmes the JANS will focus on.

9. **Think carefully about the timing of the JANS: no timing is perfect, but it is an important issue.** In Sudan, a complete and mature draft was assessed: this is preferable to a JANS which is done at too early a stage. On the other hand, the whole process of finalising the NHSSP is very delayed, given that the strategy covers the five-year period beginning January 2012. This causes problems: as well as finalising the NHSSP, the Ministry at the same time needs to think about planning the Mid-Term Review. In terms of duration, two weeks was generally regarded as appropriate for a JANS mission.

10. **The period after the JANS report is very important: there need to be specific plans to finalise the strategic document.** In Sudan, there was a long delay between the JANS report and finalising the strategy. (Indeed, the strategy had not been finalised at the time of writing, July 2013.) It is easy to lose momentum after a JANS, and it is a time when key staff may be transferred because the drafting of the strategy might be seen as completed. As part of the pre-JANS sensitisation, Ministries should be asked to allow for a period of, say, 6 weeks, when staff who have worked on the draft are given the time and encouragement to respond to the JANS recommendations and finish the strategy.

Box 3. Monitoring the seven behaviours of development partners

As described in Section 1 above, the Ministry of Health asked for one additional question to be added to the Terms of Reference for this report: *Where do the "seven behaviours" of development partners fit in and how do we monitor if this is happening?* The question was asked in the context of the development of an Aid Effectiveness Compact for Sudan to be signed by Government and development partners.

The *"seven behaviours"* are:

1. **One plan, with JANS**;
2. Resources as committed and on budget;
3. Strengthen and use country financial management systems;
4. Strengthen and use country procurement systems;
5. **Joint monitoring framework and reviews**;
6. Learning between countries;
7. Strategically planned technical support.

Given that so few partners currently channel funds through the Government of Sudan, concentrating on some of these behaviours in the short-term is premature. It was recommended to concentrate on numbers 1 and 5 – how many partners are funding activities aligned with the NHSSP and to what extent are the activities funded by various partners monitored in a co-ordinated way, without duplication of data collection and using a consistent set of indicators? To what extent do donors provide funds that are consistent with integrated service delivery, rather than on a programmatic basis?

The Ministry of Health also asked for recommendations specific to Sudan to complement the international focus of most of the lessons learned. For Sudan, the recommendations are:

1. Keep up the positive momentum for the entire planning cycle. Organise a **Mid-Term Review** (MTR) and an independent **evaluation**.
2. Plan the **governance** of the MTR and evaluation: one option would be to extend the work of the JANS Organizing Committee.
3. Continue to strengthen the **annual plans** in States and programmes. Clearly show the links with the NHSSP in terms of focussing on the same priorities.
4. Work with the Ministry of Finance as it develops and implements the **Aid Co-ordination Strategy**. The Strategy aims to bring humanitarian and development funding closer together, with more involvement of federal and state ministries.
5. The Ministry of Health **Compact** should include some modest but important short-term milestones in terms of harmonisation and alignment. One realistic short-term objective is to improve the alignment of existing support.
6. Use the opportunities of **GAVI and Global Fund applications** to demonstrate good practice in terms of how technical programmes can work in a more integrated way.
7. Continue work on **costs**; by the time of the next strategic plan, the Ministry should have a good idea of its overall cost patterns.

Annex 1. Terms of Reference: Documenting lessons learned from the Sudan JANS

Background

The International Health Partnership (IHP+) aims to accelerate progress towards the health MDGs by making international health aid more effective. IHP+ aims to mobilise support around a single national health strategy, harmonize donor funding and improve the way international and national partners work together to develop and implement national health strategies. For this to happen, sound strategies are needed, in which partners have confidence.

Joint assessment of national health strategies has, therefore, been a high priority for IHP+. A systematic assessment tool (known as JANS) was developed in 2010 by an IHP+ inter-agency working group. An increasing number of countries have used the tool formally and informally in their planning processes, to assess overall national health strategies and also programme strategies, such as for HIV or malaria.

In 2012, a consultation on lessons learned from JANS[9] agreed that there needed to be improved synergy between national health strategies and sub-sector strategies, and also between associated joint assessment processes. The latter concept was summed up by the term **'One JANS'**.

It was agreed that IHP+ would work with interested countries to do sector JANS in ways that better accommodate programme concerns, by covering agreed priority areas in more depth. It was also agreed that – rather than developing advance detailed guidance on how to do 'One JANS' – practical experience should inform further thinking on process, level of detail of analysis, etc. and would eventually lead to a paper setting out options for doing 'One JANS'.

The second element of JANS that the 2012 meeting identified as important was the need to develop more systematic follow-up to JANS in countries, and to get a better sense of what difference the JANS actually made, and what the benefits were in relation to the local objectives of the exercise.

Sudan is the first country to put the concept of 'One JANS' into practice. Agencies such as GAVI and the Global Fund are introducing new funding models. There is renewed emphasis on reducing the transaction costs of separate assessments. There is also a continuing demand for more documented experience of follow up and benefits from the exercise. There is, therefore, huge interest in the Sudan experience and what lessons it may have for similar assessments in other countries.

[9] Consultation on Lessons Learned and Future Directions of JANS

Task

To document experience of the One JANS process and follow up in Sudan, using the framework for review[10] that has been used to document lessons learned in other countries as the starting point. The consultant will cover the following core issues:

1) Description of the JANS process;
2) Assessment and lessons learned, including for future 'One JANS' assessments;
    a. On the JANS process
    b. On the JANS tool and supplementary note on issues to consider for 'One JANS'[11]
    c. On the JANS findings and their benefits.

This will involve a review of key documents such as the terms of reference for the JANS in Sudan; then face-to face or telephone interviews with a range of stakeholders who were involved in JANS preparation; conducting the JANS or in reviewing and using the findings.

Product

A short report summarizing the main lessons learned that can be widely shared, and a debriefing with key national stakeholders at the end of the mission.

[10] Approach to lesson learning from the initial joint assessments, 6 July 2010.

[11] Doing a sector JANS with a more in-depth review of selected priorities: preliminary note on issues to consider, 20 May 2012, IHP+ Core Team.

Annex 2. Persons interviewed

Ministry of Health

His Excellency Bahar Idriss Abu Garda, Federal Minister of Health
Dr Isameldin Mohammed Abdalla, Under-secretary, Federal Ministry of Health
H.E. Dr Elfatih Malik, Gezira State Minister of Health
Dr Mohamed Ali Yahia Elabassi, DG Planning and International Health
Dr Talal Elfadil Mahadi, DG PHC General
Dr Igbal A. B. Abukaraig, Public Health Institute, Director-General
Dr. Imad El Din A M Ismail, International Health Director
Dr. Zahir Ajab Alsiddeig, Health Information Centre Director
Khalid Abdelmutalab Elmardi, Communicable and non-communicable diseases
Mohamed Osman Hamid, SNAP
Magoli Salih Osman, EPI
Fatima Ibrahim Mohamed, EPI
Khalda Abdelgany, EPI
Hmooda Toto Kafy, IVM
Hiba Kamal Hamadelngo, NTP
Ethay Awadalla
Dr Taher Omer Al Sheekh, East Nile Health Centre, Khartoum State

JANS Team

Dr Jarl Chabot, Public health/health services and Team leader (telephone)
Dr. Abebe Alebachew, Economist (telephone)
Dr Bolanle O. Oyeledun, Public health (telephone)
Dr Colin Thunhurst, Epidemiology/public health; Monitoring and evaluation (telephone)
Professor Dr Mutamad Ahmed Amin, Parasitologist
Professor Dr Zein ElAbdeen Abdul Rahim Karrar, Pediatrician

Ministry of Finance
Omer Alhajam

National Council of Strategic Planning
Abass Korena
Abdel Rahim M. Al-Toum

National Assembly
Madam Somia Okoued

National Health Insurance Fund
Dr Mustafa Salih Mustafa, Director General
Dr Abdoelbishr Elsharat
Dr Sali Hassan

Development Partners
Dr. Anshu Banerjee, Country Representative, WHO
Dr Ehsanullah Tarin, WHO
Suhair Zainelabdein, WHO
Fikru Tesfaye, UNDP/Global Fund
Dorothy Ochola, UNICEF
Elfatih Abdelraheem, UNAIDS
Dr Kidane G Abraha, UNFPA
Mohamed Sidalmed, UNFPA
Laura Zampetti, European Union
Kyoko Minami, JICA
Halima Abdeen Abdalla, JICA
Maxim Berdnikov, Global Fund (telephone)
Anne Cronin, GAVI, Geneva (telephone)

NGOs

Ibtihalat Mohamed Alhassen, Almanor Organisation
Mohamed Ahmed Abdelhafez, Sudan Development Association
Dr Mohamed Awad Elkarim, ISRA
Mohamed Abdelrahman, PHF
Mukhtar Mohammed Ahmed, Sudan Family Planning Association
Sara Eltayeb, Plan Sudan
Dr Shaza Hashim Hassen, OVCI/USRATUNA

Veronica Walford, Consultant for the NHSSP (telephone)