STUDY REPORT

# Access to Health Care in South Sudan: A Qualitative Analysis of Health Pooled Fund supported counties.

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# LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| AU | African Union |
| BHI | Boma Health Initiative |
| BHT | Boma Health Team |
| BHW | Boma Health Worker |
| CEQ | Central Equatoria |
| CHD | County Health Department |
| CHW | Community Health Worker |
| CIDA | Canada International Development Agency |
| CSO | Civil Society Organisation |
| DFID | Department for International Development |
| DMP | Data Management Plan |
| EAC | East African Community |
| EHSP | Essential Health Services Project |
| EU | European Union |
| FBO | Faith Based Organisation |
| FGD | Focus Group Discussion |
| GAVI | Global Alliance for Vaccines and Immunisation |
| GESI | Gender Equity and Social Inclusion |
| HHS | Household Survey |
| HIV | Human Immune Virus |
| HPF | Health Pooled Fund |
| HSDP | Health Sector Development Plan |
| iCCM | Integrated Community Case Management |
| IDI | In-depth Interviews |
| IDP | Internally Displaced Persons |
| IGAD | Intergovernmental Authority on Development |
| KII | Key Informant Interview |
| LQAS | Lot Quality Assurance Sampling |
| MoH | Ministry of Health |
| NBS | National Bureau of Statistics |
| NGO | Non-Government Organisation |
| ODK | Open Data collection Kit |
| OECD | Organisation for Economic Co-operation and Development |
| PHCC | Primary Health Care Centre |
| PHCU | Primary Health Care Unit |
| PID | Personal Identifier |
| PoC | Protection of Civilians |
| PHC | Primary Health Care |
| REC | Research and Ethics Committee |

| | |
|---|---|
| SDG | Sustainable Development Goals |
| SIDA | Swedish International Development Agency |
| SMOH | State Ministry of Health |
| SSI | Semi-Structured Interview |
| TBA | Traditional Birth Attendants |
| UHC | Universal Health Coverage |
| UID | Unique Identifier |
| UK | United Kingdom |
| UN | United Nations |
| UNICEF | United Nations Children Fund |
| USAID | United States Agency for International Development |
| WAP | Warrap |
| WEQ | Western Equatoria |
| WHO | World Health Organisation |

# I. Executive Summary

Access and use of health services remain limited in South Sudan. It is estimated that only 44% of the population in South Sudan live within reach of health facilities and have consistent access to primary care services. Since 2012, various donor funding mechanisms have financed primary health care services in the country. The Health Pooled Fund (HPF) programme is one of these funding mechanisms. The HPF programme's goal is to establish an effective public health system that delivers improved access to quality health services which are responsive to the needs of the communities especially for children and women.

This study was undertaken to investigate access to and utilisation of health care services in the counties supported by the HPF programme to enable the identification of priority areas for reducing morbidity, disability, and mortality in South Sudan. The study is a mixed-methods study with a qualitative phase (phase 1) and a quantitative phase (phase 2). This report presents the findings of the qualitative study. Sixty-nine qualitative interviews were conducted in Western and Central Equatoria and Warrap states with individuals involved in the implementation or management of health care (33) and with users and non-users of health care services (36) across more than 30 PHCC sites. Twenty-seven focus groups discussions were also organised with key stakeholders (12) and community members (15). The main topics of the interviews and FGDs were on common health problems, health-seeking behaviour, information about health care services, the quality of care (namely on accessibility, availability, acceptability, and affordability), the role of community health workers, and the role of HPF. The findings of this study are summarised according to these topics below.

The most common health problem for all age groups across states was found to be malaria, typhoid, and pneumonia, with respondents saying that a large portion of the population suffers from chronic cough and/or diarrhoea. Respondents stated that when someone is sick, they seek care at the nearest public health facility, making distance the key determinant factor when choosing where to go.

The main reason to visit a health facility is the availability of drugs, according to respondents across all states and from all groups. Getting to a facility just to be told that the drugs or tests/equipment you need for your condition are not available was mentioned as one of the most frustrating things about seeking care in public health facilities. The kind and fair behaviour of health care workers vis-à-vis patients was another reason to seek care at a particular facility, according to some respondents.

Information about health care services and disease prevention was received through community health workers (CHW) and mobilisers, traditional leaders as well through radio, television, and social media. This included information about Coronavirus. Interviewees had a good understanding of the need to wash hands, social distance and wear a mask to prevent the spread of the virus. Health workers did say, however, that although the population was initially worried about the virus, the lack of tangible evidence that the virus was causing deaths has made most people reluctant to adapt their habits accordingly.

To assess quality of care, respondents were asked about accessibility to facilities, availability of drugs, equipment, and skills to diagnose and treat illnesses at those facilities, acceptability of the services

rendered and affordability of health care services. The single biggest barrier to accessibility was said to be transportation costs as well as poor road infrastructure in remote areas. For those living with disabilities, transportation was said to be an insurmountable issue at times. In terms of availability, all respondents complained of the shortage of drugs, specifically those used to treat some of the most common health problems. The shortage of personnel and skills was also mentioned as a major issue, creating long waiting times and the need to transfer patients to other health facilities when certain skills are unavailable.

The acceptability of services in terms of patient - health worker interaction was often problematic, with one respondent describing health workers as "*authoritarian*". Patients are made to wait in long lines and once they see the doctor they are rushed through the exam and treated rudely. Respondents blamed the low pay and short supply of staff for the bad behaviour of health facility workers. In terms of services provided, health officials mentioned that the maternity ward and immunisation and nutrition programmes for children were particularly successful. These have made a significant impact in the community, bringing down the number of mothers dying due to complications related to pregnancy or childbirth, along with reducing the prevalence of malnutrition among children. Affordability of health care is also an issue. Although health care in public facilities is supposed to be free of charge, most respondents reported having to pay a small "*registration fee.*" In certain facilities, the need to pay informal/unexpected fees for medicines or specific services was sometimes mentioned. These costs were said to have an impact on patient's ability to access care.

Community health workers performed a critical function in terms of linking health facilities up with areas that were difficult to access. They are widely lauded by health workers and patients alike for covering the gap that health care facilities are unable to fill and providing mobile outreach through people from those communities. They describe their main responsibilities to be health education, basic treatment, referral to health facilities, and household monitoring of malnutrition. The main challenges community health workers face are the large catchment areas they need to cover, and a lack of financing, transport, and appropriate training.

Respondents asked about Health Pool Funded (HPF) programming generally associated the programme with improvements in maternal and child health in their communities, as well as improved care for those living with HIV. However, health care workers and county health officials conveyed dissatisfaction with the fact that incentives paid to health workers and the number of facilities being supported had been decreased in this current iteration of HPF programming.

# II. Introduction: Background and Justification

## Introduction

According to the 2019 World Health Organization (WHO) statement to mark the World Health day, half the world's population cannot access essential health services (1). Millions of women give birth without help from a skilled attendant; millions of children miss out on vaccinations against killer diseases, and millions suffer and die because they cannot get treatment for malaria, HIV and TB. As part of the Sustainable Development Goals (SDG), under SDG 3, all member countries have committed to achieving universal health coverage (UHC) by 2030. In order to meet this target, one billion people need to benefit from UHC in the next five years (1).

In most African countries including South Sudan, the progresses towards the Universal Health Coverage (UHC) have been slow (2). Compared to other regions of the world, sub-Saharan Africa has the lowest satisfaction with health care (3). The underfunding of primary care systems has been identified as one of the challenges that Sub-Saharan countries face to achieve UHC (4). The quality of maternity care in primary care facilities is reported lower than in secondary care facilities (5), and primary care facilities often lack basic elements of infrastructure like water, and electricity (6). While the Abuja Declaration (7), signed in 2001 by African Union countries, urged all states to allocate 15% of national budgets towards health, less than 2% of South Sudan's national budget goes toward the health ministry (8). Some health professionals are of the view that there needs to be a change of strategy in fragile and conflict-affected countries, such as South Sudan, if ailing health systems are going to improve (8).

The chronic conflict in South Sudan has left the health system underdeveloped with non-governmental (NGOs) and faith-based organisations (FBOs) providing approximately 70% of services (9). Since 2012, a donor funding mechanism (i.e., the US Agency for International Development (USAID), World Bank (WB) and Health Pooled Fund (HPF) led by the UK Department for International Development (DFID) now referred to as Foreign Commonwealth and Development office (FCDO) has financed primary healthcare services across the ten (10) states of South Sudan (10). Similar to Afghanistan, South Sudan implements a Basic Package of Health and Nutrition Services (BPHNS) for all citizens, often contracted to non-state providers (11).

The Health Pooled Fund (HPF) South Sudan is a multi-donor fund led by the United Kingdom's Department for International Development (DFID) now referred to as Foreign Commonwealth and Development Office (FCDO). Other donors include the Government of Canada (CIDA), the Swedish International Development and Cooperation Agency (SIDA), United States Agency for International Development (USAID), the GAVI - the Vaccine Alliance, and the European Union (EU). The HPF programme aims at establishing an effective public health system that delivers improved access to quality health services that are responsive to the needs of the communities. The main focus is on reducing maternal and child morbidity and mortality. The HPF programme has gone through 2 phases of funding namely HPF1 (2012-2016) and HPF2 (2016-2018). The programme is now in its 3rd phase (HPF3) which started in October 2018 with the bridging period and now in full implementation. This research focused on access to health care services in the HPF supported counties in South Sudan.

## Contextual background

South Sudan attained independence on July 09, 2011 and is member of the United Nations (UN), African Union (AU), the Intergovernmental Authority on Development (IGAD) and the East African Community (EAC). South Sudan lies between latitudes 3° and 13°N, and longitudes 24° and 36°E. It is covered in tropical forest, swamps, and grassland. The Republic of South Sudan has a surface area of 640,000 square kilometres, with an estimated population of 12.3 million, annual growth rate of 3.2% and total fertility rate of 7[1]. Approximately 83% of the population live in rural areas. The low population density (15/square kilometre) coupled with mobile pastoral communities and limited access due to the protracted crises poses a huge challenge to health service delivery. As of February 15th, 2020, a presidential decree, reverted the country to ten states and three administrative areas, which are further sub-divided into 85 counties, 545 Payams and 2,500 Bomas[1].

South Sudan has some of the worst health indicators in the world, affecting mainly children and women. The maternal mortality ratio is estimated to be 1150 deaths per 100,000 live births, child mortality rate at 99 per 1,000 live births, and infant mortality rate at 65 per 1,000 live birth (12). The conflicts have led to widespread looting, destruction of health facilities, and massive displacements of citizens, mostly children and women in hard-to-reach areas where basic health services are not available (10, 12). It is estimated that approximately 44% of the population in South Sudan live within reach of health facilities and have consistent access to primary care services (13, 14). Currently, the health system is faced with major bottlenecks for community health services such as lack of equipment, frequent stock outs of drugs and medical supplies, low acceptance of community health services, lack of qualified CHW/BHW candidates, insufficient remuneration, limited capacity of MoH supervisors and limited linkages between the CHWs/BHWs and the health facilities (15). Presently, the country health system is funded through two funding mechanism namely, the Health Pooled Fund (HPF) through a consortium led by Crown Agents (UK) and the other is Essential Health Services Project (EHSP) funded by World Bank (WB) through a consortium led by UNICEF.

The HPF3 programme supports delivery of essential primary care at the community, primary health care facilities, secondary care facilities and referral hospitals. The programme supports the strengthening of the referral systems at all levels of health care. The programme also supports the stabilisation of local health systems and the strengthening of community ownership and governance structures. Finally, HPF3 is responsible for the procurement and supply chain management of essential medical commodities with the last mile distribution done by implementing partners (IPs) contracted to provide the health services in selected counties. It is anticipated that the programme will lead to improved health and nutrition status for the population that saves lives and reduces morbidity (including maternal, infant and under-5 mortality).

At the time of independence in 2011 and most recently as of 15th February 2020, South Sudan is divided into 10 states. The donors still provide funding and services based on this number of states. Currently, HPF programme supports 8 out of the 10 states and the remaining 2 states are supported by the World Bank through a consortium led by UNICEF. The HPF programme supports a total of 55 counties, 181

[1] South Sudan Ministry of Health (2018). The Draft South Sudan National Health Sector Strategic Plan_2017-2022. pg16. Feb 2018

Payams (average 4-6 per county), and 1461 Bomas. In South Sudan, a Boma is the smallest administrative unit nearest to the community and comprise of a number of villages that may range from 6-10. The health service delivery in South Sudan is decentralised with each level having specific activities. The national ministry of health (MoH) sets policies, strategic plans, mobilises resources, sets standards and guidelines and assures quality of health services. The state ministry of health (SMoH) translates policies, while County health departments (CHD) implement primary health care activities through the networks of health facilities and community structures.

Health services delivery is based on three tiers; firstly, the primary care which consists of community structure known as the Boma Health Teams (BHTs), Primary Health Care Units (PHCUs) and Primary Health Care Centres (PHCCs). Secondly, the secondary care which has the county Hospitals and state Hospitals. Thirdly, the tertiary care which has national teaching, specialist, and referral hospitals. These structures are aligned to the administrative units of the country[1]. The HPF3 programme supports a total of 794 health facilities at different levels of care including: 25 hospitals (3%), 192 Primary Health Care Centres (PHCC) (24%) and 577 Primary Health Care Units (73%). The services are provided by the county health departments (CHDs) and with support from the Lot implementing partners (IPs) that have been contracted by the HPF3 consortium lead. The lots are smaller geographical areas contracted to the IPs in which HPF3 programmes are implemented.

One of the thematic areas in HPF3 programme is the expansion of curative and promotive health services at the community level through the Boma Health Initiative (BHI). The BHI strategy is a government-led programme which was officially launched by the South Sudan government in March 2017 and aimed at improving equitable access to health care services. The BHI is designed to increase demand, access, and awareness of health services for the preventive and promotive services. Based on this strategy, community health workers (CHWs) also referred to as Boma Health Workers (BHWs) are trained to deliver a standard, package of promotional, preventive, and selected curative health services at the Boma level phased in over a predetermined period. This approach is expected to improve the current inequity in accessing health services. According to the information available from the Ministry of Health (MoH) at least 56% of the population of South Sudan live further than five kilometres from a health facility, which contributes to some of the worst health indicators globally, which is, in part, due to very limited access to health services (13).

Access and use of health services remain limited due to a number of factors affecting the health systems, health seeking and social determinants. Accessing health care comprises the possibility to identify health care needs, to seek health care services, to reach health care resources, to utilise health care services and to actually be offered services as appropriate to the needs for care. These dimensions are influenced by determinants from the provider side (approachability, acceptability, availability and accommodation, affordability, and appropriateness) and the demand side which influence a person's ability to perceive, seek, reach, pay and engage with health care (16). Health care seeking behaviour refers to the factors influencing the behaviour of people with respect to seeking and using care continuing to use care when required and adherence to advice and treatment given (17). For example, in South Sudan, the common barriers to accessing reproductive health services include lack of information on available services, cultural attitudes and misconceptions, early marriages and lack of preparedness by expectant mothers

and families (15). It is therefore envisaged that this information gap will be filled if the BHI is embraced and fully supported as a means of reaching out to the communities in need of these health services.

A health care seeking behaviour study done in the neighbouring Ethiopia, found that health care seeking behaviour for childhood illnesses was delayed and decision to seek care from health facilities was influenced by worsening of the illnesses (18); which provided insight in emphasizing, through community level promotion, the need of prompt health care seeking for childhood illnesses in the locality. Another Ethiopian health care seeking behaviour survey among households where at least one person had been sick in the 2 months prior to the visit showed that the percentage of people who sought care from a modern health facility was lower among rural (48.1%) compared to urban (80.7%) (19). Higher monthly income, perceived severity of disease, acute duration of disease and short distance from health facility were statistically significant associated with modern health care utilisation in the rural population, while being married and perceived severity association were statistically significantly associated with modern health care utilisation in urban areas. Self-medication was widely practiced. The findings signal the need to work more on accessibility and promotion of health care seeking behaviour especially among rural households.

In the past two decades several household surveys have been conducted in South Sudan. The South Sudan Household Health Survey conducted in 2010, a national representative survey of households, among women and men aged 15-49 years and children aged 0-5 years generated knowledge on the general well-being of woman and children in South Sudan (20). The survey aimed to collect health and related indicators essential to identifying women, men, and children's health needs and for establishing priorities for evidence-based planning, decision making and reporting. Information was collected on child mortality, nutrition, child health (i.e., vaccinations coverage, care of illness); water and sanitation, reproductive health, education, child protection, HIV/AIDS, sexual behaviour, and orphaned and vulnerable children.

The South Sudan Lot Quality Assurance Survey (LQAS) 2015 (21) showed that for maternal health, in comparison to 2011, moderate improvement in nine indicators was measured, only the proportion of woman practicing any form of modern family planning saw a slight reduction. The percentage woman who delivered in a health facility during their last pregnancy reached 25% at national level but mainly due to relatively high coverage from three states (Central Equatoria, Western Bahr el Gazhal and Western Equatoria). Disappointing low indicators included the following indicators "pregnant woman who had four or more ANC visits" (drop of 30% from those who had one ANC visit); "mothers who had at least 1 postpartum check-up" and "mothers' knowledge of mother-to-child transmission of HIV and understanding at least 2 ways to protect against the sexual transmission of HIV" and "rejection of major misconceptions". With respect to child health indicators, the percentage of caregivers who sought treatment for their children with suspected acute respiratory tract infection (ARI) within 24 hours declined compared to 2011 (22.9% to 13.7% while target is set on 60%) while generally vaccination rates in children under 1 year saw steady progress since 2011. Only a third of the 64%-65% (overall 21%) of children suffering from fever were taken to an appropriate health care provider within the crucial first 24 hours while the health strategic development plan (HSDP) target is set at 70%. For diarrhoea this was 22.4% (no target was set).

A survey among the beneficiaries, done in March 2018 as part of evaluation of the HPF phase two programmes (HPF2) in four counties of Warrap and Lakes States (n=287), showed a reasonable amount of satisfaction with a number of services, mostly with malaria, diarrhoea and immunisation, and an average level of satisfaction with other services such as maternal and child healthcare & family planning services (22). The HPF2 evaluation report mentioned some the barriers to accessing health services in South Sudan which included:

*Geographical access*: Only 44% of the population living within 5km of a health facility (source MoH interviews during evaluation) and approximately 86% of people not using an HPF facility indicated that this was due to closest facility being far and therefore community outreach is essential in mitigating the low coverage of health facilities (22). However, another study done in South Sudan by Macharia and colleagues in 2017, revealed that only 25.7% of the population living within one hour walking time to a facility and 28.6% of the population within 5km (23).

*Quality*: The HPF2 evaluation also revealed that health advocacy and education work had led to more individuals seeking health care, therefore increasing the patient load, and making it more challenging to provide quality care. Additionally, the beneficiary survey respondent's satisfaction with drug availability was low with 46% of respondents indicating that drugs being mostly available was a reason for choosing to use an HPF-supported facility (22). Therefore, availability of drugs is a key element of service quality provided by the HPF programme.

*Cost*: Despite the fact that primary services are meant to be free of charge for patients at the point of service delivery, as enshrined in the South Sudan constitution, 32% of respondents in the beneficiary survey indicated that they pay a fee, particularly at Primary Health Care Centres (PHCCs) and Primary Health Care Units (PHCUs). The values of user fees are unknown (22). Unclear if fees were paid to staff directly or reflected the costs of buying drugs in private market due to stock-outs. Considering the underfunding of facilities and the poor remuneration of staff, it would not be surprising that facilities try to supplement their resources by charging fees, nor that staff supplement their individual income by illegally charging patients. However, considering the impact that user fees could have on affordability of services for more vulnerable people, it would be beneficial for the programme to gain a better understanding of what these costs entail and agree on how to tackle the issue in line with the MoH policy. It is stated that HPF should explore the issue of user fees and address if it is a barrier to access (22). Despite this, only a few respondents indicated cost as a reason for not visiting a health facility. At least 68% indicated that services were free, and one third mentioned affordable cost as a reason for choosing an HPF-supported facility, indicating that cost does not seem to be a major barrier in the four lots covered by the evaluation (22).

*Lack of disability services*: The HPF 2 evaluation found no evidence that GESI was addressed in health interventions and responses under the programme. From the beneficiary survey under this evaluation, 46% of the respondents reported at least one difficulty (seeing, hearing, walking, or climbing, remembering or concentration, self-care, communication) (22).

Given these finding from the HPF 2 programme, it was anticipated that the third phase of HPF (HPF3) programme would work with the MoH to put in place measures to improve access to health services to

all the citizens of the country. A qualitative study done by Kane and colleagues in 2015 (24), in Wau county of the Western Bahr el Gazhal State, showed that while accessibility, affordability, and perceptions (need and quality of care) related barriers to the use of maternal health services exist and are important, women's decisions to use services are also shaped by a variety of social fears. Societal interactions entailed in the process of going to a health facility, interactions with other people, particularly other women on the facility premises, and the care encounters with health workers, are moments where women are afraid of experiencing dignity violations. The authors found that in South Sudan, the social norm is that a pregnant woman is expected to be well taken care of and should be seen to be well taken care of, by her man and his family; the appearance of being well taken care of, socially dignifies the woman's pregnancy. Another mixed methodology study by Lawry and others (25), conducted a study to understand the barriers to health care for women, new-borns, and children in Gogrial West, Warrap State, South Sudan, found that barriers to care for mothers, infants and children are far more than the lack of antenatal care. Maternal, newborn and child health suffers from lack of skilled providers, resources, distance to clinics. Lack of gender equity and accepted negative social norms impedes healthy behaviours among women and children (25).

## Problem Statement

In the context of South Sudan, coverage and accessibility remain important challenges to improve primary health care delivery. Less than half of the South Sudanese population is within 5km of a health care facility, and the estimates vary between 44% (13, 14, 22) to 28.6% (23) depending on the sources. This translates in population having to walk one hour or more before they reach any health facility. Reaching a health facility may, however not mean that the needed or most appropriate care is available; such problem is exemplified by patients' low satisfaction with availability of key drugs (HPF Beneficiary survey), or the fact that 36% (22) of respondents reported being referred to a higher-level facility because of complications, lack of expertise, equipment, or medication at the initial health facility of arrival, as well as social stigma and stereotypes. While technically free, primary care services still incur shadow costs for patients, this is in particular due to the low wage of health care providers or the necessity to finance running facilities. Consequently, 32% of users have reported having to pay fees in primary health care centre and units, the lowest level of the health system (22). This creates further barrier to care, especially for the most vulnerable population that may not have the possibility to pay for fees or medications. From this, several factors impede access and utilisation of health care by patients. Distance, availability, and quality of services all impact negatively access to care. As such community outreach becomes a critical strategy to the implementation by the HPF programme not only to inform patients of the utility of travelling to a facility, but also what service could be expected at the nearest facility. Furthermore, the impact of the community outreach activities under the BHI strategy allows to inform the community of the services available and when to use them, as lack of information is an important factor in decision on health care seeking behaviour. Finally, the community outreach system also functions as a sortation system, allowing to release pressure on health facilities while minor ailments can be identified and potentially treated without a necessary and uncertain passage at a health facility.

## Justification

The HPF3 programme aims at reducing maternal and child mortality rates in South Sudan through the delivery of a basic package of health and nutrition services; promoting community engagement in health

as a public good; and local health systems stabilisation. Therefore, the health seeking behaviour and access survey is expected to assist the programme in understanding the reasons why people seek healthcare from given healthcare providers, including facilities, and not from the others in HPF supported counties (4). This is important for the programme to know what is preventing the citizens from using the services in the supported health facilities and what can be done to improve the current status for future programming and implementation.

## III. Purpose and Scope

The purpose of the study was to provide the HPF programme with information on why some people use their services while others do not, and what can be done in order to improve future implementation and programming. The study's overall goal was to investigate access to and utilisation of health care services in the counties supported by the HPF programme to enable identification of priority areas for reducing morbidity, disability, and mortality in South Sudan. The specific objectives are:

- To assess the most prevalent health care needs within the communities living in payams with HPF (phase 3) funded health activities.
- To assess factors affecting healthcare seeking behaviours and access to health care services of communities living in payams with HPF (phase 3) funded health activities.
- To assess the awareness and utilisation of the community health services provided by the Community health workers (CHWs).
- To identify the citizen's concerns and perceptions of access to and quality of care within the catchment areas of HPF supported health facilities.
- To provide evidence-based knowledge on barriers, enablers, and preferences regarding health care seeking behaviours in areas supported by the HPF (phase 3) programme.

*Considerations of sampling area*

The HPF3 programme is implemented in eight states namely: Central Equatoria, Eastern Equatoria. Northern Bahr el Gazhal, Western Bahr el Ghazal, Unity, Western Equatoria, Warrap and Lakes. The three states were selected taking into considerations the following issues summarised in table 1:

- Implementation status of HPF programme,
- Accessibility,
- Areas with relative security and stability for at least 6 months to 1 year,
- Level of Boma Health Initiative (BHI) implementation,
- Available qualified local researchers,
- Urban and rural areas,
- Characteristics of people in various regions such as nomads/pastoralists and settled/peasant farmers,
- Excluded Protection of civilian camps (PoC) and other internally displaced persons (IDPs) camps since services in those camps are provided by other emergency humanitarian actors.

**Table 1: Sample of states, counties, and reasons for consideration**

| State name | # hospitals | # PHCC | # PHCU | # counties | 30 % of counties selected | Name of selected counties | Considerations |
|---|---|---|---|---|---|---|---|
| Warrap | 4 | 19 | 72 | 06 | 2 counties | Gogrial West, Twic | These two counties had previously implemented integrated community case management of malaria, pneumonia, and diarrhoea for children <5years (iCCM) and were among those where the pilot for the BHI was done in 2018 and these counties are mainly inhabited by and also mainly pastoralists. |
| Western Equatoria | 6 | 31 | 108 | 10 | 3 counties | Maridi, Yambio, Tambura | These are counties with relative stability, however, compared to the number of health facilities in these locations, there are fewer health facilities supported by HPF3 compared to those that were supported under the previous HPF phases (1 & 2). These counties were not iCCM counties and in 2019, HPF did not support BHI in these counties. (Security, fewer supported facilities, and no iCCM or BHI in the previous years). These are basically inhabited by peasant farmers. |
| Central Equatoria | 3 | 32 | 66 | 6 | 1 urban county selected | Juba | Purposefully selected due to its urban setting, implemented iCCM and in 2019 HPF supported implementation of BHI |

We used a mixed-methods approach to collect and analyse the data for this study. The study is being carried out sequentially, in two phases: a qualitative phase (first phase) followed by a quantitative phase (second phase), which will be informed by the qualitative phase.

This report presents the methodology (chapter IV), findings (chapter (V), conclusions and recommendations (chapter VI) of the qualitative research (phase 1).

# IV. Methodology

We conducted interviews with individuals involved in the implementation or management of health care services (e.g., HPF state coordinators and county health department officials) and with users and non-users of health care services (e.g., adolescent, and adult community members); as well as focus groups with key stakeholders (e.g., Boma Health Committee members) and community members (e.g., persons with disabilities). See the table in Appendix 1 for an overview of study participants.

*Study Preparations*

In preparation for fieldwork, approval for the study was required from the Ministry of Health (MoH) and the National Bureau of Statistics (NBS). In addition, permissions were sought from the Governor's and Mayor's offices as well as from other local authorities (e.g., county commissioners, payam administrators, and Boma chiefs) before data collection commenced.

*Recruitment*

For phase 1, we recruited and trained three researchers with significant experience in qualitative research to conduct the interviews and moderate the focus group discussions in the three study locations. The recruitment and training took place between August 10 and August 18, 2020. One researcher was deployed per state based on their ability to speak the predominant language in the selected counties and their knowledge of the local context (i.e., an Azande researcher was sent to Western Equatoria, a Dinka speaker from the Bahr-el-Ghazal region was sent to Warrap, and a Bari/Juba Arabic speaker was deployed in Juba County). Whenever possible, the same researchers will be deployed for phase 2 where each will recruit, train, and supervise a team of six enumerators from a roster of locally based individuals who have previously conducted household surveys for Forcier Consulting Ltd.

*Training*

Prior to travel to the field for each phase, the researchers attended two days of training (separate training for each phase), led by a Forcier Research Officer at the Forcier Juba office. The training covered project background, the research tools, sampling methodology and study procedures. There was also a refresher training on research ethics. Standard translations of the questionnaire and guides to commonly spoken languages in the three study locations (i.e., Juba Arabic, Dinka, Bari, and Pazande) was agreed upon at that time. The researcher training included role plays to pre-test the focus group and interview guides.

*Piloting*

We conducted a one-day pilot exercise for the qualitative component and will do the same for the quantitative component in Juba. For the qualitative portion, we conducted one focus group with female adolescents and two semi-structured interviews with one adult male or female participant and one health facility worker in Juba. Given the limited number of key informants, we were not able to conduct an interview with a key informant during the pilot test.

*Selection of research sites*

The sampling for the qualitative component was entirely purposive and was guided by information provided by key informants at the state and county levels. Before arrival to the state, each researcher, with support from the Research Officer, scheduled interviews with the HPF state coordinator, a state health official knowledgeable about the HPF programme (the HPF state coordinator provided a name), a representative of implementing partners of the HPF programme (the HPF state coordinator provided a name), and a representative of other NGOs (non-HPF) working in the health sector in the state (the HPF state coordinator provided a name). Upon arrival in the field, the researcher conducted these interviews starting with the HPF state coordinator followed by the state health official and then representatives of NGOs.

These interviews were crucial in determining which counties and PHCCs were to be included and which participants were to be recruited for the interviews and focus group discussions (FGDs). The county health department official, who was interviewed as a key stakeholder, was recommended by the state health official. Once this county health department official was identified, she/he was asked to recommend one PHCC that has a functional health committee, medium level of performance in terms of service utilisation, and minimum number of health workers (at least 5) in his/her county. Table 1 provides the study locations.

**Table 2. Study locations: Catchment Areas**

| State | County | PHCC |
|---|---|---|
| Western Equatoria | Yambio | Bazungua |
| Central Equatoria | Juba | Nyakuron |
| Warrap | Gogrial West | Gogrial |

All subsequent interviews (e.g., with payam officials, Boma health committee members, and traditional leaders) and FGDs were with participants that came from the catchment area of the selected PHCC. This recruitment approach was chosen to minimise logistical challenges and associated financial costs in moving between counties when trying to conduct interviews and FGDs with participants from different counties. It also ensured same units of analysis and similar contexts across all three study locations.

The qualitative data collection methods utilised, and the participants sampled are further described below.

**SSIs**: The SSIs were conducted with a semi-structured framework which allowed focused, conversational, two-way communication. The researcher followed a guide (one for key stakeholders and one for study populations, Appendix 2 and 3 respectively) but was also able to interrogate topical trajectories in the conversation that may stray from the guide when it seemed appropriate. In each state, the researcher conducted 21 SSIs with key stakeholders and community members including community leaders, different groups of service users, health authorities at the county and payam levels, health committees, HPF implementing partners, health workers, community members, local media, and NGOs/FBOs.

**KIIs**: The KIIs involved interviewing people who had particularly informed perspectives on an aspect of the HPF programme or who had a deep understanding of the health system at the state and county levels. Each researcher conducted two KIIs (i.e., with the HPF state coordinator and a state health official actively involved in the HPF programme).

**FGDs**: In each state, the researcher recruited participants for the FGDs by obtaining contact information from HPF, recruiting through the village chief, or through a snowball sampling strategy. The researcher moderated 9 FGDs with key stakeholders and community members including Boma and county level health officials, community health workers, and male and female adolescents and adults. The findings from the SSIs, which were held before the FGDs, were used to adapt, and revise the FGD guides for the key stakeholders and community members. Each FGD comprised of 6-8 participants who shared similar

characteristics (e.g., FGD with male adolescents, FGD with community health workers, and FGD with persons with disabilities). The FGD guides (the tool for key stakeholders can be found in Appendix 4 and the tool for study populations can be found in Appendix 5) contained open-ended questions to explore participant-specific topics informed by the SSIs, but they also contained a few generic questions to allow cross-group comparison.

*Translation and Transcription*

The majority of the interviews and FGDs were conducted in the main local languages spoken in the study locations. We deployed researchers based on their ability to fluently speak the predominant language (s) in their assigned study location. Audio files of completed interviews and FGDs were downloaded to password-protected Forcier-owned computers and transcribed by a dedicated team of nine transcribers recruited and trained by Forcier for this exercise. The transcribers consisted of individuals fluent in Dinka, Bari, Pazande, Juba Arabic, or classical Arabic. They listened to the audio files and directly translate them to English, capturing as much of the original content as possible. Transcripts were reviewed for accuracy and completeness by Forcier Research Officers fluent in the language of the transcribed audio files.

*Quality Assurance*

The Forcier research team put in place several measures to assure quality of the data collected during the study. The specific quality assurance measures are described below.

- The training of the researchers, followed by testing and supervised practice, was the first quality assurance step. The training emphasised the importance of collecting high quality data. The researchers practiced conducting interviews and moderating FGDs among themselves and the Research Officer provided feedback to each researcher, especially on how they handled the consent process and probing during the mock interviews/FGDs.
- Once data collection started, the Forcier research team listened to the interview/FGD audio files and review interview/FGD notes as often as interview uploads were possible from the field and provided feedback to each researcher on areas to improve and mistakes to avoid for future interviews/FGDs. The review process was most intensive during the first 2-3 days of qualitative data collection, where all audio files and notes were reviewed each day. Once the quality of interviewing was deemed acceptable, a sample of 20% of audio files and notes were reviewed daily as part of our quality assurance process. Feedback was provided to the researchers before the start of fieldwork the following day. For the transcription team, the first quality assurance step was also during the training. The transcribers underwent a special one-day training where a significant amount of time was spent on practicing translation and transcription of audio files from the pilot. Once transcription of the fieldwork data started, the Forcier research team reviewed the transcripts/notes for typos, grammatical errors, accuracy, and completeness as they became available. Where responses did not flow well or where the meaning of responses was not clear, translations were compared against original audio recordings and referred to the researcher for clarification. Subsequently, edits were made to reflect the actual intended responses. The research team conducted random checks of the audio files against transcripts to verify the completeness and validity of the completed transcripts.

*Qualitative data analysis*

The cleaned transcripts of the qualitative interviews and FGDs were uploaded to Atlas.ti for analysis. The KIT and Forcier research teams conducted preliminary content analysis of the qualitative data to identify any common patterns and trends arising from the narratives regarding: a) health seeking behaviours; b) perceptions of and experiences with the five dimensions of quality (i.e., availability, accessibility, affordability, adequacy, and acceptability); and c) potential additional emerging themes. In consultation with KIT, Forcier developed a coding framework/book and a thematic analysis guide that was uploaded to Atlas.ti to facilitate the coding process. The coding framework, included in Appendix 6, contained fields for codes and their definitions associated with the codes.

We used Atlas.ti to support the analysis of the qualitative data, first comparing themes (difference and similarities) in similar groups (e.g., key stakeholders) and second by stratifying themes by gender, age, profession, and authority. The narratives were written on the main themes and illustrated by county-specific data whenever possible.

# V. Findings

This section of the report summarises the research findings. Respondents were first asked about the common health problems found in their communities and about their health seeking behaviour- when and where they sought care and what characteristics of a health facility encourages them or discourages them from visiting. They were also asked where and how community members access health information.

Next, interviewees were questioned on the various dimensions of quality of care - accessibility, availability, acceptability, and affordability and how or if they were able to provide feedback about the quality of care.

Finally, they were asked about the Boma health Initiative (BHI), how Coronavirus has affected their health seeking behaviour and respondents were asked to provide specific feedback about the Health Pool funded programming. The following sections summarise the findings.

## Common health problems

Respondents were first asked to speak about the most common health problems in their communities, especially those faced by their particular demographic - men, women, adolescents, children, and people with disabilities. Nearly all respondents named malaria as the most common health problem in their communities – for men, women, and children.[2] Typhoid, pneumonia and HIV were also mentioned by the majority of respondents as common health problems.[3]

[2] SSI_WAP_06_BHC2

[3] FGD_CEQ_06_CHD

A number of stomach illnesses were mentioned, such as worms and ulcers, albeit by a smaller proportion of respondents. Sexually transmitted diseases were reported as being prevalent among adolescents and adults – specifically syphilis, gonorrhoea, and HIV. Epilepsy was also mentioned by a number of respondents in Western and Central Equatoria as a common health problem, along with tuberculosis and Hepatitis B and C. There was no appreciable difference by state in terms of the types of diseases that respondents named as being most common. Poverty was said to lead to a higher prevalence of malnutrition and sanitation-based diseases (e.g., Typhoid) among the most vulnerable populations in food-insecure, rural areas.

When respondents listed the symptoms that were most common in their communities, the majority of respondents spoke of people suffering from chronic acute coughs.[4] Women often complained of "*abdominal pains/sickness*," while children were reported to have diarrhoea. Headaches or fever were also commonly cited symptoms that are highly general in nature. Swelling in legs and rashes on their skin were also mentioned as a common health issue. The data revealed specific health problems by gender, age, and ability.

*Men*:
A few diseases were mentioned as being more common among men, specifically: hernias, appendicitis, and ulcers. Respondents also suggested that men (more than women) suffered from drug and alcohol abuse or addictions.[5] Some respondents also suggested that men, more than women, tended to engage in reckless driving, which is attributed to road accidents that lead to serious injuries and that are often fatal.[6]

*Women:*
Urinary tract infections (UTIs) were said to be the most common health problem facing women and Pelvic Inflammatory disease (PID) was cited as being the primary cause of infertility among women. Postpartum haemorrhaging, and other complications arising from labour, as well as death in childbirth, were described as the biggest health issues afflicting mothers. Similarly, women mentioned maternal deaths during miscarriages, when a child dies inside her body "*and rots*" or "*during the operation to remove a dead baby*."[7] Malnutrition during pregnancy and breastfeeding was also mentioned by a number of respondents as a major public health issue.[8] Respondents also suggested that pregnant women tended to be more susceptible to infections and more likely to have complications as a result of common diseases while pregnant.[9] During a focus group discussion with women, respondents emphasized the issue of menstruation and women's lack of access to sanitary pads leading to women needing to remain home during their menstrual period each month.[10]

[4] SSI_WAP_03_15M, SSI_WAP_16_OTH2
[5] FGD_CEQ_09_CHW, FGD_CEQ_06_CHD
[6] FGD_WAP_06_CHD
[7] SSI_WEQ_09_PGO
[8] FGD_WAP_06_CHD
[9] SSI_WAP_07_CHW1
[10] FGD_WEQ_01_15F

*Children:*
Among children under five years of age, diarrhoea diseases were said to be the most common disease symptoms observed, along with coughing.[11] The most common diseases that respondents cited were malaria, typhoid, and pneumonia.[12] Malnutrition was mentioned as "*something that paralyses children.*"[13] Meningitis and measles was also said to afflict children due to low vaccination.

*Adolescents*:
The issue of alcohol addiction and related mental health issues was mentioned as being a problem that particularly affected young men.[14] For young women, early pregnancy was repeated as a common issue. The fact that girls who would generally be at school are now at home due to school closures has been attributed to an increase in early pregnancy.[15] Complications arising from early pregnancy and delivery, including death, was also mentioned. STIs, especially syphilis, gonorrhoea, and HIV, were listed as common health problems for adolescents in general.[16]

*Marginalized groups*:
The older population was said to be suffering from hypertension, diabetes, and pain in their joints. A number of respondents who were living with disabilities mentioned the fact that they are "*moving on the ground and crawling on the mud*" to get from one place to another and thus are exposed to many diseases that often make them ill.[17] Disabled persons are also recognised as suffering from all the other common diseases in South Sudan, including malaria, typhoid, cough, and diarrhoea. In addition, respondents suggested that debilitating diseases like polio and meningitis may have contributed to their own disabilities and to the general prevalence of disability in the population.[18]

## Health Seeking Behaviour

Respondents were asked about where they went to access health services when they were ill and about the factors that made them decide to go there. Across states, two key decision-making factors were discussed in terms of where patients chose to seek medical care: general affordability of care, and availability of drugs. The issue of affordability was said to drive most people's decisions about when and where to seek healthcare. People receive care, free of charge, in public hospitals and facilities, and that is why most people choose those facilities. Those who were financially able, sought care in private clinics because they believe that drugs are more available and reliable at such clinics (albeit at a much higher price than in public hospitals). Some respondents said that difficulties in accessing drugs in public health

[11] FGD_WAP_02_20F, FGD_CEQ_04_20M, FGD_CEQ_02_20F
[12] KII_WAP_02_SHO, FGD_WAP_09_CHW, FGD_WAP_04_29M
[13] SSI_WAP_08_TL1, SSI_CEQ_16_OTH1, FGD_WAP_06_CHD
[14] SSI_CEQ_16_OTH2
[15] SSI_CEQ_09_PGO, SSI_CEQ_06_BHC2
[16] SSI_CEQ_16_OTH1
[17] FGD_WEQ_05_PWL
[18] SSI_CEQ_13_PWL, FGD_WAP_02_20F

facilities as well as their inability to pay private clinic fees has forced people to turn to traditional medicine.[19]

The distance patients need to travel to receive care was another major decision-making factor mentioned by respondents. Many respondents said that they cannot afford transportation and so any health facility that is within walking distance becomes the preferred health facility.[20] Illustrating this problem, one respondent said: "*preference is also limited because any nearby health facility automatically becomes a preferred health facility because you don't have options.*"[21]

In Central Equatoria, respondents said they tended to seek care at Nyakuron health facility and that if the illness were too serious to be cared for there, they would be transferred to Juba teaching hospitals. Respondents suggested that children were often sent to Al-Sabah hospital.[22] However, respondents from Central Equatoria also complained of the cleanliness of Nyakuron health facility and complained of the lack of drugs there.[23]

In Warrap, respondents reported that they tend to go to Gogrial PHCC for basic health issues and go to Kuajok hospital when the illness is more complicated.[24]

Most of those in Western Equatoria suggested that when they are sick, they seek care in the Bazungua PHCC and that more serious cases are taken to the Yambio teaching hospital.

Across regions, respondents mentioned that people's awareness of the services provided in the health facility are improving, mostly due to word of mouth. When one person in a village or community has a good experience in a health facility, they often bring that information to others in the area, which has led to an increase in people seeking professional medical help rather than resorting to traditional medicine.[25]

Respondents were also asked to describe the characteristics of an ideal health facility. The single most important characteristic that respondents noted was that the best health facilities have all necessary drugs and medicines.[26] Respondents explained that the lack of medicines was often a reason why patients might need to leave one facility and seek care elsewhere. In some cases, it was said that patients would be given prescriptions for drugs by a facility where they had sought care, but then they were asked to go purchase the drugs at a clinic outside of the facility where they had originally sought care. Because drug prices at private pharmacies and clinics are often higher than at public healthcare facilities,

[19] KII_WEQ_01_HPF, FGD_WAP_02_20F

[20] KII_WAP_02_SHO, SSI_CEQ_01_15F, SSI_CEQ_11_IP

[21] SSI_CEQ_14_CSO,

[22] SSI_CEQ_05_HFW

[23] FGD_CEQ_03_15M

[24] FGD_WAP_02_20F

[25] SSI_WEQ_04_20M, FGD_WAP_05_PWL

[26] SSI_WAP_14_CSO, SSI_WAP_16_OTH1

respondents said that they found they could ultimately not afford the drugs prescribed. This dynamic has led to patients being reluctant to seek medical care in the future.[27]

The second most important characteristic that respondents cited as contributing to an ideal health facility was the commitment and general disposition of nurses and doctors. When doctors were caring and showed empathy towards their patients, patients were satisfied with the care they received and were happy to come back to the facility in the future, if the need arose.[28] When a patient's interaction with a health facility worker was negative, they would be less likely to want to come back in the future. As one respondent summed it up, "*a health facility where the health workers are authoritarian and a health facility without medicine – there is no motive to access that facility*."[29]

Thirdly, respondents mentioned that fair and equal treatment among patients was important to them when deciding whether to use a given health facility. Respondents stated a preference for facilities where they were certain that all people, from children to elderly, to the disabled, would be seen and treated for their diseases.[30] Those living with disabilities most often mentioned the issue of being treated as if "*there was no hope*", rather than being provided with quality health care. One interviewee said, "*what discourages us from the hospital, people with disability, is people do not look at us as human beings because we are disabled, since we are blind or a person who does not walk […], people no longer have hope in us, saying we are supposed to be left out to die.*"[31]

Other key characteristics of a good health facility were said to include minimal waiting time as well as longer time spent seeing the doctor.[32] Respondents said that they have a higher level of satisfaction with their visits if they felt like they were able to spend more time with doctors in ways that made them feel like the doctors attended to their needs and questions and clearly explained their diagnoses. Respondents also mentioned preferring qualified doctors they could trust. Finally, as a fifth concern, some respondents said that they also cared about the levels of cleanliness in the facility they were visiting as well as the degree to which the facility had adequate rooms or spaced to allow for privacy during consultation.[33]

## Information Sources

Respondents were then asked about how information about health services is disseminated within their areas. Community members reported receiving health-related information through community health workers and community leaders, as well as through the radio and through visits to the health facility themselves.

[27] SSI_WEQ_08_TL2, FGD_CEQ_02_20F

[28] FGD_WEQ_06_CHD, FGD_WEQ_03_15M

[29] KII_WEQ_02_SHO

[30] FGD_WEQ_05_PWL,

[31] SSI_WEQ_13_PWL

[32] SSI_CEQ_11_IP, SSI_CEQ_08_TL1, SSI_CEQ_01_15F

[33] SSI_WEQ_11_IP, SSI_WAP-07_CHW1

Respondents named community health workers as playing a central role. Community health workers or mobilisers were described as, "*people that move through the community*" who provide information about immunisation for children and other health concerns, most recently about Coronavirus.[34] Community health workers are also said to disseminate information about hygiene and sanitation as well as ways to stop the spread of HIV. Community health workers spread information by visiting households and community mobilisers, or community-based organizations, as well as using megaphones to spread information at busy intersections, markets and in churches.[35]

Many respondents mentioned that their preferred source of information are these community mobilisers who come door to door. Respondents stated that they appreciate the way that community mobilisers are approachable and accessible to members of a community.[36] The Respondents living with disabilities were less positive about the roles of community mobilisers and said they would prefer to have disability centres dispensing information, or other methods through which information catered specifically to people with disabilities could be delivered.[37]

According to respondents, information is spread through the radio and is given out to students at schools.[38] A few respondents said they received information through traditional leaders or women's leaders or Boma Health committees and by word of mouth, from those who visit health facilities and come back and tell their communities about it.[39]

Despite there being a diverse set of information sources cited by respondents, many barriers to access to health information remain. The most cited barrier is living in remote villages where people do not have access to community mobilisers or health workers. The reason for lack of mobilisers and health workers is often said to be bad or non-existent roads or living on the far side of a river that is difficult to cross.[40] The rainy season tends to exacerbate these access constraints.[41] It was also mentioned that some people do not have radios and thus cannot access this information through this medium.[42]

Interviews also suggested that there is a substantial amount of and disinformation in sampled communities. A few respondents said that they have been receiving contradictory information from different people and organizations that are ostensibly in charge of communicating health information and raising awareness within the sampled communities. One respondent said, "*they spread information about COVID-19 today, tomorrow you hear different statements about COVID-19.*"[43]

[34] FGD_CEQ_09_CHW
[35] SSI_WAP_16_OTH3
[36] SSI_CEQ_04_20M
[37] FGD_CEQ_05_PWL
[38] FGD_CEQ_01_15F
[39] SSI_WEQ_05_HFW, FGD_WEQ_01_15F, SSI_WEQ_16_OTH3, SSI_WAP_16_OTH1, SSI_CEQ_06_BHC2
[40] SSI_WEQ_16_OTH3
[41] SSI_WEQ_16_OTH1
[42] SSI_WEQ_16_OTH3, SSI_CEQ_12_ONGO, SSI_CEQ_07_CHW1
[43] SSI_WEQ_15_LM

## Coronavirus

Respondents were asked about their understanding of the Coronavirus, signs and symptoms of the virus and measures to prevent the spread. They were also asked where they had received such information and how it may have affected people's health seeking behaviour.

### Health Knowledge

The majority of respondents interviewed across states had heard of the Coronavirus and its symptoms – cough, fever, and difficulty breathing – and had received the general guidelines about the need to maintain social-distancing, wear masks, and wash hands frequently.[44] Respondents also said they were told not to have public gatherings such as funerals or weddings and not to shake hands.[45] A few respondents added that they thought that they could avoid contracting Coronavirus by boiling water before drinking it or by abstaining from sex.[46]

People with disabilities reported unique problems that they have faced due to the pandemic. They said that they need physical help, meaning that people need to touch them or carry them, something people have been more reluctant to do because of the pandemic. According to one respondent, *"[Coronavirus] divided us very badly because most of our issues need touch, others need to be held, others need to be directed by holding the hand. It brought us very big challenges."*[47] In some communities, people with disabilities were even stigmatised as being carriers of the virus.[48]

There were also some misconceptions about the virus. For example, some people believed that those wearing the masks were those who had the virus. This is why masks have never been worn by the population as a whole, people said they were afraid of being stigmatized for wearing a mask.[49] Another respondent said that in Western Equatoria, people's initial reaction to COVID-19 was that NGO and UN workers must have brought the virus to their country. Thus, some people did not want their children touched by foreign aid workers during nutrition screening.[50]

Some respondents said that the one good thing about the virus is that it has led to the availability of water and soap in places where it had not been previously available, and that people were generally trying to wash their hands more often and whenever possible.[51] As one respondent explained, "*Since COVID-19 entered it has brought a lot of improvement in terms of health; you will see that everybody is at home washing, even the young children will know what health is, even they can wash hands.*"[52]

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[44] SSI_WEQ_08_TL1, SSI_WQP_16_OTH2
[45] SSI_CEQ_08_TL2
[46] SSI_WEQ_09_PGO
[47] SSI_WEQ_13_PWL
[48] FGD_CEQ__05_PWL
[49] SSI_WAP_ONGO
[50] SSI_WEQ_12_ONGO
[51] FGD_WEQ_07_BHC
[52] FGD_CEQ_08_HFW

### Information source

Similar to how people get other health-related information, respondents reported having received information about COVID-19 through the radio, news and social media channels as well as through information disseminated by the health facilities and community health workers.[53] A respondent said that, "*I think that the radios are playing a very big role in displaying information about COVID-19 and as I told you also the hospital, if you enter through the main gate here and also in other PHCC, you will find that there is a washing facility with someone that will tell that you have to wash and of course you will ask why I should wash and they will tell you.*"[54]

A CSO in Western Equatoria stated that they do radio talk shows and disseminate information to priests and churches who then speak about COVID-19 to their communities.[55] In Warrap, one respondent said GOAL and HPF organized radio talk shows to disseminate information about COVID-19.[56] Other respondents also said they received information about the virus through their church.[57]

The government was also said to have trained people at the county level to do awareness-raising in communities around the virus by informing heads/leaders of communities, so that they, in turn, would speak to their communities and put up informative signs and posters.[58] A Boma health committee member in Central Equatoria reported having been offered an informative workshop on Coronavirus by the national Ministry of Health and that they then disseminated the information to the communities, including telling people about the existence of a hotline number they could dial in case they, or someone they knew, may be infected.[59] A health facility worker in Western Equatoria mentioned they made arrangements with the chiefs and other stakeholders, did a mobile clinic outreach holding talks across different places, and trained the Boma Health Initiative members to provide health education about COVID in churches they frequent[60].

### Corona-induced changes in health seeking behaviour.

According to one respondent, hospitals and health facilities were attempting to limit people's visits by giving HIV patients a six-month supply of medicines rather than having them come weekly, and by giving malnutrition patients monthly rations rather than on a bi-weekly basis.[61] Respondents also reported a change in the procedure at the entrance of health facilities. They are asked to wash their hands before entering, they have to wear a mask inside and facility workers take patient's temperature and limit the

[53] FGD_CEQ_05_PWL, FGD_WAP_01_15F, SSI_WAP_13_PWL, FGD_WEQ_03_15M
[54] SSI_WEQ_16_OTH3
[55] SSI_WEQ_14_CSO
[56] SSI_WAP_16_OTH2
[57] SSI_WEQ_13_PWL, FGD_CEQ_02_20F
[58] SSI_WAP_06_BHC1, SSI_CEQ_16_OTH1, SSI_CEQ_01_15F
[59] SSI_CEQ_06_BHC2, SSI_WAP_12_ONGO
[60] SSI_WEQ_05_HFW
[61] SSI_WEQ_12_ONGO

number of people allowed in at one time.[62] A few respondents said that the fact that mask wearing had become compulsory inside hospitals and health facilities has created a new barrier to access, as some people are unable to afford one.[63]

It was reported that initially people did not come to the facilities as often following the coronavirus outbreak, as they feared catching the disease there, especially since the facilities are usually crowded with people who have travelled from different areas.[64] People were also reportedly afraid to get tested for coronavirus when they were exhibiting symptoms, since they believed a positive test would mean forced quarantine and possibly dying alone. One respondent explained that, "*They were fearing to go to the hospital, because if you got the sickness, immediately you are taken to stay alone, you are taken, then end up dying there. That's why people were not going to the hospital.*"[65]

People reportedly only made the trip to the see doctors when they were seriously ill.[66] However, since July, people were beginning to visit facilities in numbers that were similar to those before the outbreak.[67] There are few signs of the presence of the virus in their midst, and although people were initially worried, they no longer think about it much.[68] According to respondents, the general population is not wearing masks, nor are they taking all the necessary preventative measures.

## Quality of Health Care

This section summarises findings in terms of citizens' concerns and perceptions of access to and quality of care within the catchment areas of HPF supported health facilities. Respondents were asked about their access, both physical and other, to the health facility, the availability of drugs, equipment, and skills necessary to diagnose and treat the communities' aliments, the acceptability of the services rendered in terms of their interaction with health facility workers, the physical space and the breath of services available, and finally how affordable the care is for them.

### Accessibility

The main accessibility problem that respondents reported related to their **distance to the nearest health facility**, and the **availability and affordability of transportation**. In some areas, respondents said they were able to reach the facility on foot and that it only took a few minutes to get there. In other, more remote areas, respondents said it took several hours, or at times close to an entire day, even when using a motorbike or other vehicles.[69] Physical accessibility was said to be even more complicated for respondents who lived in extremely remote areas with little to no road infrastructure. One respondent

[62] SSI_WEQ_06_BHC1, FGD_CEQ_07_BHC
[63] SSI_CEQ_07_CHW2, FGD_CEQ_04_20M
[64] SSI_CEQ_08_TL1, FGD_CEQ_09_CHW
[65] SSI_CEQ_07_CHW1, SSI_CEQ_06_BHC1, SSI_WEQ_05_HFW
[66] SSI_WEQ_05_HFW, SSI_WAP_16_OTH2
[67] SSI_WAP_12_ONGO
[68] SSI_WEQ_10_CHD
[69] SSI_WAP_07_CHW2

said, "*small places without roads through which a vehicle can pass, which are just village roads with many streams. To take a patient you will have to carry a patient, plus the bicycle to cross the stream one at a time, so it takes around five to seven hours.*"[70] Flooding was also mentioned by respondents in Central Equatoria and Warrap as a contributing factor to hindered access.[71] Getting to the health facility at night or very early morning, when it is dark outside, was reported as even more difficult by respondents in all three states due to general insecurity and banditry along roadways.[72]

Physical accessibility to a facility was reported as an even more significant challenge for those too ill to move on their own, for women in labour, and for those living with disabilities.[73] A respondent living with disabilities said they needed to rely on someone to take them to the nearest health facility, and said that help was not always available.[74] They also complained that boda-boda or motorcycle drivers hired to take them to the facility charge more to transport disabled persons, as the drivers have to physically help their passengers get from their house to vehicle and from the vehicle into the medical facility.[75] A community health care worker, while describing the challenges faced by those with disabilities in accessing the health facility said, "*sometimes they get by the roadside trying to reach the health facility and they find a good Samaritan like a boda-boda driver, who might help them.*"[76] Accessing the inside of the facility is also an issue due to the lack of handicap infrastructure, such as ramps for wheelchairs.[77]

Ambulances were said to not be readily available to respond to the needs of disabled persons. One respondent in Warrap said that ambulance rules are that it transports only pregnant women or children, but not adults or the elderly.[78] He said, "*if you are an adult and you don't have any mean of transport and the rules of the ambulance say that you are eligible for transportation, then you may not have choice, but stay with sickness because you don't have any other means to get transport to the health facility.*"[79]

Although a number of respondents said that the **opening time of the health facilities** was good, the fact that the facilities were not open on weekends or in the evening was considered problematic.[80] Facilities were said to open around 8 or 9am and close by 5pm and since they were not open 24 hours a day, they could not be accessed in an emergency during off hours.[81] Respondents said that people with minor health issues who work during the day were most likely not going to spend a work-day visiting a health facility, which translates into limited accessibility to health care for those individuals. [82] One female

[70] FGD_WEQ_07_BHC
[71] FGD_WAP_07_BHC, FGD_CEQ_07_BHC
[72] FGD_WEQ_03_15M, FGD_WEQ_06_CHD, FG_CEQ_09_CHW, FGD_WAP_07_BHC
[73] FGD_WEQ_07_BHC, KII_WEQ_01_HPF, FGD_CEQ_09_CHW, FGD_WAP_02_20F
[74] FGD_WEQ_05_PWL
[75] SSI_WEQ_13_PWL
[76] FGD_CEQ_09_CHW
[77] SSI_CEQ_13_PWL
[78] FGD_WEQ_06_CHD
[79] FGD_WAP_05_PLW
[80] SSI_CEQ_03_15M
[81] SSI_WEQ_16_OTH2, FGD_CEQ_09_CHW
[82] SSI_WEQ_16_OTH3

respondent did mention that the maternity ward in their area was open 24 hours a day, but this was exceptional, and most respondents reported that their health facilities had limited hours and could not respond well to emergencies.[83]

Accessing the appropriate care once a patient physically reached the facility was also reported as an issue. Respondents indicated that some patients would arrive at a given facility only to discover that they needed to be transferred to other facilities since the facility that they went to first did not have the proper equipment, qualified staff, and/or drugs to provide treatment for their condition. One respondent said, "*the community also faces challenges when they come from very far to the facilities. When you reach the facility, you are being told there is no check-up for Malaria, there is no check-up for Typhoid, and this drug for your condition is not there.*"[84] Some patients were reportedly pressured to go to a private clinic which they could not afford for issues such as malaria and typhoid check-ups. In another case, due to the lack of communication between facilities, a patient with malaria was mistakenly referred to and subsequently transferred from one facility to another in a way that took extra time and was unproductive.[85]

## Availability

### *a.* *Drugs and treatment*

Next, respondents were asked about the availability of drugs, equipment, and skills in the health facilities. The single biggest problem mentioned by almost every respondent was the **lack in availability of drugs**. Certain types of drugs (e.g. artesunate, artemether, and PPF injections) were reported to be completely unavailable while others (e.g. amoxycillin, oxytocin, progesterone oral pills (POP) for lactating mothers etc, were in short supply.[86] Almost every respondent complained that even if they were to overcome all the other barriers to accessing health care – long /expensive trip to the health facility, long wait times, lack of skills to diagnose their issue properly – often times their health-seeking journey would end with them going home without having received treatment because the drug they needed was not available and/or they were told to go purchase it from a private clinic at rates that they could not afford.[87] This is the single most frustrating issue named by potential patients, and a key factor that affects health seeking behaviour, as some patients avoid the health system all together because of it. One health worker said, "*those who are coming here, and they do not get drugs, they will go back in the community and discourage others that even if you go, you will not get drugs, there is nothing there so let us go and do the herbs at home and use that one and meanwhile what they are doing, children are dying and even our adults are dying.*"[88]

[83] SSI_WEQ_16_OTH3

[84] FGD_WEQ_06_CHD

[85] FGD_WEQ_06_CHD

[86] FGD_CEQ_08_HFW, SSI_CEQ_08_TL2

[87] FGD_CEQ_07_BHC

[88] FGD_WEQ_08_HFW

The lack of drugs in health facilities affects those living with disabilities more acutely than others since their journey to the health facilities is often more costly and more complicated. This problem is illustrated by the following quote from a person living with disabilities in Warrap: "*No, it does not make people happy because I will come in the morning like at around 7am and I will find the doctors are not there and when they come, I will be told to join the line. Even in the line I will still wait in the line, yet again I am hungry, and I am feeling pain, but they will tell you there are no drugs, this makes you regret having come – like at least, if I had remained at home, I would be resting and taking porridge. So, these are things that make us angry with doctors and you will go unhappy, and if they give you drugs you will go back happy, because you have spent a lot of time. So, in this hospital we are not happy, we are suffering a lot because there are no drugs.*"[89]

Health care workers and patients alike have mentioned the fact that drug supplies often run out. Health care workers said that drugs are typically delivered on a quarterly basis only, and that the quantities of drugs delivered each quarter seldom last the full 3-month period.[90] As one healthcare worker explained: "*When the drugs have been brought, we normally look at the quantity and how long it is going to take, but unfortunately we may find that after only one month or two months the drugs are no longer there. So, what happens is that there is a problem, we are receiving many patients, so the drugs that are being supplied to us is little.*"[91] According to some respondents, however, the issue of the lack of drugs is explained by mismanagement of supply by doctors and/or some of it being sold on the black market.[92] One respondent said, "*you will find RDT, which is government property, but we find them on the market, why are they on the market? It is written not for sale.*"[93]

One of the ways in which health facility workers seem to be coping with the issue of short supply is by rationing out the amounts of medications they give each patient. For example, "*patients sometimes are not given complete treatment due to shortage of drugs in the store*."[94] This strategy of rationing treatments was also cited by a number of patients who claimed that they only received half the dosage of malaria medications or antibiotics that were actually required for their treatment, and thus they finished the medications they were given and found that they were still not fully recovered.

More specifically, **short supply of malaria medications** was the most widely reported issue by staff and patients alike. Malaria is one of the most common health problems in the area, making this a frequent problem.[95] One health worker explained, "*We are facing challenges especially due to the inadequate supply of Malaria drugs, because sometimes we don't have enough drugs for Malaria in the pharmacy, and especially the fluids when it's coming to complicated Malaria, we cannot get fluids for administering drugs like Quinine.*"[96] Only tablets are given for malaria but if one needs injections, they need to pay for

[89] FGD_WAP_05_PWL
[90] FGD_WAP_08_HFW, FGD_CEQ_08_HFW, FGD_WAP_07_BHC
[91] FGD_WEQ_06_CHD
[92] FGD_WAP_05_PWL, FGD_WAP_04_20M
[93] FGD_WAP_04_20M
[94] FGD_WEQ_06_CHD
[95] FGD_WEQ_07_BHC, SSI_WEQ_12_ONGO
[96] FGD_WEQ_06_CHD

it. As the community health worker said, "*tablets are given and within two weeks, the patient is sick again.*"[97] A county health department official said, "*drugs like paracetamol, amoxicillin, the anti-malaria drugs, injections, these ones at least cannot reach one month before getting finished because especially if it is malaria season, these children they are coming with severe malaria.*"[98] Drugs for other common health problems such as pneumonia and diarrhoea were also reported to be in short supply.[99]

*b. Equipment*

Health care workers also mentioned that they tend to **lack adequate working equipment** and they also often have **inadequate numbers of tests to diagnose illnesses**.[100] One example is a health facility worker in Warrap who said they do not have aspirators in the maternity ward and have a low supply of ventilators.[101] Another respondent in Western Equatoria said rapid tests for malaria are in high demand, and health care facilities were said to run out of tests frequently.[102] Another health care worker gave an example of diagnostic tests for hepatitis, among other diseases, that are often unavailable, hindering their ability to diagnose and treat their patients: "*When a mother comes for testing, when we refer the mother to the lab, when they came back there [is] no testing, it is out of stock, this is another challenge for us the staff.*"[103] Other things like TB tests and thermometers were said to be lacking in certain facilities.[104]

Because of shortages of supplies, it was reported that patients were typically not given **food or mosquito nets** once they were admitted.[105] The lack of nets increases the possibility of malaria infection for in-patients and with no food service being available, in-patients can end up being under-nourished and feeling tired and weak.[106] Respondents also mentioned that **reliable power sources** were often in short supply. In the past, solar panels had been installed in a number of facilities, but in many cases those panels had been looted or destroyed during conflicts and not replaced. In other facilities once-functional lighting systems had been damaged by weather or fire and were never repaired. These problems have left many facilities with only diesel generators to power the facility, which is a costly and sometimes unreliable solution (given the fuel shortages).[107]

Respondents suggested that ambulances are not reliable and there are also too few ambulances available to respond to emergencies.[108] One Boma Health Committee member said "*Sometimes they call*

[97] FGD_CEQ_09_CHW
[98] FGD_WEQ_08_HFW
[99] FGD_WEQ_06_CHD
[100] FGD_WEQ_07_BHC, FGD_CEQ_07_BHC
[101] FGD_WAP_08_FHW
[102] FGD_WEQ_07_CHD
[103] FGD_WEQ_08_HFW
[104] SSI_WAP_03_15M
[105] FGD_WAP_08_HFW
[106] FGD_WAP_08_HFW, FGD_WAP_03_15M
[107] SSI_WAP_07_CHW2, KII_WEQ_01_HPF
[108] KII_WEQ_05_HFW, SSI_WAP_06_BHC1

*a vehicle called 'Embros' (Ambulance); it comes sometimes, sometimes it fails to come. And then there comes a challenge of how the patients will be taken, us in the committee we try to contribute when a sickness arises so we can take a motor bike for our patients to be transported there or if there is any means, we use it to transport them there*."[109]

The availability of space in the health facilities was also mentioned as a problem, especially the lack of sufficient beds or rooms to admit patients.[110] A direct effect of the lack of temporary admissions beds is that medicines like Quinine are more difficult to administer, so healthcare workers sometimes provide alternative treatments (such as artesunate and amodiaquine) that may be less effective, simply because of lack of appropriate space within which to administer a treatment.[111]

*c. Skills*

A **shortage of qualified health care personnel** was another issue mentioned by the majority of respondents.[112] Respondents reported that doctors and nurses are consistently overworked, and people are left to wait for hours to see a health care worker because there are so few qualified professionals. One traditional leader mentioned the fact that there is only one person on staff per department and that with the volume of people coming to the facility to seek medical attention, the number of personnel simply was not enough to meet demand.[113]

The main reason provided for the short supply of drugs, tests, and staff was that a single health facility is required to cover a large catchment area. At any given time, only a handful of health facilities within a large region may be fully functional, and so people from all over the wider area are forced to all come to the same facility, putting large amounts of stress on drug and equipment supplies and personnel. As one respondent explained, "*facilities with smaller populations and then also facilities which are close to each other that are functional, at least drugs always remain, but when you find facilities that are far and facilities which are not functional around, you know their drugs actually finish faster. Also, those facilities with higher population, their drugs get finished faster and we normally do drugs rotation - when we find that drugs are finishing in one of the health facilities, we rotate to keep availability of drugs in health facilities.*"[114] Respondents also cited problems with transportation in the supply chains that support health facilities, especially during the rainy seasons when roads are in very bad condition. During the rainy season, trucks transporting drugs and other medical supplies sometimes get stuck for days on the road, leading to delays in delivery and further contributing to temporary shortages.[115]

*d. Services*

[109] SSI_WEQ_06_BHC1
[110] SSI_WAP_02_20F, FGD_WEQ_06_CHD
[111] FGD_WEQ_06_CHD
[112] FGD_WAP_03_15M
[113] SSI_WEQ_08_TL1
[114] SSI_WEQ_11_IP
[115] SSI_WEQ_16_OTH3, SSI_CEQ_12_ONGO

Despite the drug shortages and shortages of necessary personnel being a pervasive problem, some departments and services were highlighted by respondents as being available and adequate. The hospitals and health facilities were also said to have all the necessary services in terms of prenatal/maternity/family planning services, immunisation, HIV/AIDS support as well as general health services.[116] Many respondents spoke **positively of the expanding immunisation programme, the antenatal care provided, the HIV unit as well as the nutrition programme**.[117] A number of respondents in both Western Equatoria and Centra Equatoria said that the support given to HIV patients was particularly good, especially the provision of flour, beans and cooking oil which helped them with nutrition.[118] Multiple respondents also spoke of the confidentiality that comes with testing positive for HIV and how they appreciate this.[119]

Furthermore, the maternity ward was singled out as being available 24 hours a day, in contrast with other health services. One health worker spoke of the dropping numbers of maternal deaths since his arrival in 2016, thanks to the programme. He mentioned there had been only one death the previous year and he was hoping to end the year with no deaths at all.[120] Similarly, respondents in Western Equatoria (Bazungua) mentioned the overall shifts happening in their communities – primarily that children are not as thin as they used to be and that women are not dying during childbirth as frequently as they used to.[121] Children are also being immunised and thus are tending to not get diseases such as polio. People with HIV have better access to care as compared to before.

Respondents also suggested that, in contrast to most drugs, there was an **adequate supply of vaccines**. Mothers reported bringing their children in regularly so that they receive the necessary vaccines on time, and did not report problems with vaccine supply.[122] A number of respondents also affirmed the availability of "*paste and porridge*" given to children and adults who are underweight and so fewer children are dying of malnutrition in the area.[123] HIV patients were said to be receiving nutritional help that was reported to be helping to improve their condition.[124] An additional component that was bringing help to the community in Yambio County is the support to survivors of gender-based violence.[125]

One respondent living with a disability mentioned the fact that recently a **focal person for people living with disabilities** has been made available in the facility. This focal-point person registers the names of the disabled and makes sure they get the care they need. The respondent who spoke about the focal

[116] SSI_WAP_03_15M, SSI_WAP_04_20M

[117] SSI_CEQ_07_CHW1, KII_WAP_02_SHO, SSI_WEQ_11_IP, SSI_WEQ_14_CSO, SSI_WAP_05_HFW

[118] FGD_WEQ_07_BHC, SSI_CEQ_08_TL1

[119] SSI_CEQ_04_20M

[120] SSI_WEQ_16_OTH3, FGD_WEQ_07_BHC

[121] FGD_WEQ_07_BHC, FGD_WEQ_04_20M,

[122] SSI_WEQ_14_CSO, FGD_WEQ_07_BHC, SSI_WEQ_14_PWL

[123] FGD_WEQ_02_20F, FGD_WEQ_09_CHW

[124] FGD_WEQ_02_20F

[125] SSI_WEQ_11_IP

person also mentioned that this was a major improvement and that they hoped to continue to be provided with specialized care.[126]

In Warrap, a number of respondents mentioned that the situation of the health services and availability of drugs has deteriorated with HPF. Prior to HPF programming, MSF seemed to be running the hospital and World Vision used to pay health workers' incentives, which were better than the current pay and hospital situation.[127] Respondents in Western and Central Equatoria, however, reported positive changes over the past two years, with an increase in the number of operational facilities in Central Equatoria, as well as an increase number of working days.[128] Some respondents in Central Equatoria also said drug availability is now better than it was a few years ago.[129]

*e. Awareness*

Finally, some respondents spoke about their **community's level of awareness** about how to prevent certain diseases, and when and where to seek help. Several respondents mentioned that **mosquito nets were being delivered to communities**, especially to pregnant women and that they were being told to use them to prevent malaria.[130] Awareness raising on **Family planning** was another activity the facilities were said to be involved in.

A number of respondents complained that there remain large gaps in people's health awareness. According to these respondents, people tend to be poorly informed about their health needs and therefore do not go to health facilities if/when necessary. One respondent gave the example of the lack of awareness around HIV/AIDS prevention and how it is affecting the spread of the disease. He reported that people are not seeking the help they need once they have it, thus adversely affecting their own health outcomes and endangering others.[131] Awareness around when and how to treat mental illness also remains low despite the reported availability of the service.[132] Respondents believed more should be done to improve people's awareness of common diseases, as well as how to prevent them, and how to treat them.

## Acceptability

*a. Patient-provider interaction*

Respondents were asked about their interaction with health care workers and three main themes arose. First, **long waiting times** were reported across states and health facilities. Second, **health care workers' behaviour towards patients,** were reported to be an issue in Central Equatoria and Warrap, while these

[126] SSI_WEQ_13_PWL
[127] FGD_WAP_05_PWL, FGD_WAP_02_20F, SSI_WAP-12_ONGO
[128] FGD_CEQ_BHC, FGD_CEQ_06_CHD
[129] FGD_CEQ_03_15M
[130] SSI_WEQ_08_TL1
[131] KII_WEQ_01_HPF
[132] FGD_WEQ_09_CHW

same problems did not seem to arise in Western Equatoria (specifically Bazungua health facility). **Language barriers** were not reported to be problematic, although in all states, respondents mentioned the need to resort to translators when patients did not know how to speak Arabic or English.

Across all states, the single most prevalent issue cited was **the long waiting times**. According to respondents, the wait time is always a minimum of a two or more hours.[133] The process of seeking care ends up being very long due to all the waiting the patient has to do between each step of care: i.e. seeing the doctor, having a consultation or getting tested, waiting for results.[134] It was clear to respondents that the reason for this was the large number of people coming to the same facility. "*The waiting time is long because there are many patients coming because there are very few functional health facilities and also few health workers; that is my problem, few health facilities, few health workers, and I mean the demand is also high, the demand for health services.*"[135]

Related to wait time is the issue of when doctors arrive in the morning and start seeing patients. Respondents in Western Equatoria said that the gates of the facility opened at 7 in the morning and that doctors arrived shortly thereafter. In Central Equatoria, however, respondents said it was unclear when doctors arrived and that sometimes patients would have to wait until 10 or even 12 (noon) for the doctors to arrive.[136] In Warrap, some respondents said doctors came on time, while others said that doctors tended to arrive at 10am.[137]

A large number of respondents complained of the rude way doctors and nurses treat and speak to patients, especially in Warrap. Respondents described doctors and nurses who would hurry them along or barely listen to them before sending them away. Respondents said that it was not always clear to patients why they had been sent away so abruptly; however, it was recognized by respondents across all states sampled that, on a daily basis, the number of patients vastly exceeded the capacity of doctors to tend to them thoroughly and attentively.[138]

In Central Equatoria, a substantial number of respondents complained of unprofessional behaviour of health care workers. One traditional leader pointed to midwives who spoke badly of the women they were seeing, as well as doctors who spent no time with patients to understand the patient's illness or affliction before sending them away.[139] The midwives in one health facility were reportedly refusing to discharge women who did not pay a fee (that should not have been solicited).[140] In the Nyakuron PHCC another respondent said that a doctor was refusing to provide care if the patient had not paid a fee (even though care should have been provided for free).[141] Another interviewee spoke about a doctor who

[133] SSI_WEQ_08_TL1

[134] FGD_CEQ_04_20M

[135] SSI_CEQ_14_CSO

[136] SSI_CEQ_13_PWL, SSI_CEQ_06_BHC1, FGD_CEQ_05_PWL, FGD_CEQ_03_15M, FGD_CEQ_01_15F

[137] FGD_WAP_04_20M, FGD_WAP_02_20F

[138] SSI_WEQ_07_CHW2

[139] SSI_CEQ_08_TL2

[140] SSI_CEQ_07_CHW1

[141] FGD_CEQ_03_15M

everyone complains about because of his behaviour vis-à-vis his patients.[142] Still another respondent provided an example of how he was in line to see a doctor, but then a woman arrived and was tended to immediately even though he had been waiting before her. He said, "*maybe she was a friend […] this is what we are facing, they are not treating people in the right way.*"[143]

In Warrap, respondents had complaints about similar issues they faced at Kuajok hospital, especially with a woman doctor who was said to mistreat pregnant women who came to see her.[144] Other interviewees also spoke of a doctor that has a bad reputation in the community for some of his behaviours.[145]

In contrast, respondents in Western Equatoria said that doctors and nurses were well-liked and respected in their communities. They also said that the doctors are doing a good job and prescribing medicines that are helping patients recover and get well.[146] Some respondents praised specific health care workers, telling stories like: "*Especially there is a woman here she works day and night, starting from the places that are behind here all over; this woman delivers pregnant women day and nights but there is not any support she gets, she just sits to do the work of God.*"[147] Workers at Bazungua PHCC were singled out by a number of respondents as being particularly kind and attentive in their interactions with people, especially the midwives.[148]

A respondent living with disabilities stressed that the doctors in Bazungua (Western Equatoria) cared for them well and are welcoming and kind. "*They are welcoming us as people with disability because the person with disability, everything for them is challenging, they are not fine. How they are looked at is also different, but we are welcomed and cared for very well. We do not have that problem here at Bazungua.*"[149] The same respondent also was grateful for the privacy HIV patients receive there.

In Western Equatoria, a number of respondents spoke of the problem of different languages being spoken by health care workers and patients, with the workers speaking Arabic and English, not the local language (Azande).[150] However, many workers also said that language is not a major issue or there are translators that come and help.[151] In Central Equatoria respondents saw languages as a bigger problem. Respondents in Central Equatoria said that doctors working in health facilities are often not from the local population, as that area may not have any doctors and so they have to bring someone from a

[142] SSI_CEQ_08_TL1
[143] SSI_CEQ_04_20M
[144] FGD_WAP_01_15F
[145] SSI_WAP_13_PWL
[146] FGD_WEQ_04_20M, SSI_WEQ_07_CHW2
[147] SSI_WEQ_06_BHC2
[148] SSI_WEQ_06_BHC2, FGD_WEQ_07_BHC, FGD_WEQ_04_20M
[149] SSI_WEQ_13_PWL
[150] SSI_WEQ_08_TL2
[151] SSI_WEQ_01_15F, SSI_WEQ_07_CHW2

different state.[152] In Warrap, respondents said this was not an issue and that doctors are able to communicate well with patients.

*b. Physical space*

Concerns with the physical acceptability of the health facilities were primarily related to the **lack of space and lack of sufficient beds for patients**. Other issues that varied across states included **crumbling infrastructure, lack of running water, and cleanliness**. Respondents in every state brought up the problem of **toilets** at the health facilities. According to respondents, toilets tended to be dirty, or clogged. In Warrap, respondents reported that heavy rainfall would sometimes cause latrine structures to collapse.[153] The problem of **intermittent electricity supply** was also mentioned across states and facilities.

In Western Equatoria, a number of respondents mentioned the need to renovate the old buildings and said that some buildings were built of mud and were crumbling. Other respondents spoke of leaking roofs as being a widespread problem.[154] Some healthcare workers did say that they have spoken to donors and partners about their infrastructure concerns but were told that there was no budget allocated to renovations or improvements.[155]

In addition, respondents complained of how small the hospital was and that patients are crowded into two small rooms. A traditional leader said that, despite the hospital being nice, it is much too small to support the needs of the community. "*The hospital they built us is very small, we ask they should come and build more, the houses are small but has only big fence. This is a challenge for us here in Bazungua. How we can say it so the government can look into it and support us in this regard?*"[156] Infrastructure to support those with disabilities, such as ramps, is simply not available.[157]

In contrast, respondents from Western Equatoria said that partners and donors have improved access to water and sanitation by digging a well or building a water source and building latrines.[158]

In Warrap, respondents complained about lack of running water, insufficient fuel to run generators, and cramped working conditions. A few respondents rhetorically asked how it could be possible to have no water to wash one's hands in a health facility.[159] A number of respondents also complained that there

[152] SSI_CEQ_12_ONGO
[153] KII_WAP_01_HPF
[154] SSI_WEQ_14_CSO, SSI_WEQ_09_PGO
[155] SSI_WEQ_16_OTH2
[156] SSI_WEQ_08_TL1
[157] SSI_WEQ_13_PWL
[158] FGD_WEQ_03_15M
[159] KII_WAP_01_HPF

were so few beds in the health facility that patients were being forced to share beds.[160] Respondents also complained that a very small number of ambulances were being forced to serve a large area.[161]

In Central Equatoria, respondents also complained of a lack of hospital beds.[162] As in other states, respondents in Central Equatoria also complained of cramped conditions in health facilities and lack of physical space to accommodate the large number of people visiting the facility.[163] Respondents from Central Equatoria were also the only respondents to complain of dirty facilities. One respondent said that they feared they would catch a disease by simply visiting the facility.[164]

*c. Technical quality*

Health workers across all states reported that registration tools are up to date and are being used, that treatment guidelines and emergency protocol procedures are in place and working, and that safety protocols and drug distribution processes are followed and hospital-specific waste management systems are available.[165] One health facility worker said, "*so, these things, how we handle them, like we are using gloves and then using face masks and then needle; so, if we have to work with them, then we keep them in the safety box, when the safety box is full, we can go to the incinerator, because we have an incinerator here, then we go and burn them.*"[166] One HPF respondent noted that, although guidelines may be available, it can be challenging to assess the extent to which the guidelines are actually being followed.[167]

Proper integration of services was also reported by a majority of knowledgeable respondents. One health care worker said, "*some of the services are properly integrated, you look at immunisation, it is properly integrated in the general services, so that even when a mother brings her child for other sicknesses, they, the people in the facility, will give her the treatment and the medication and they say this child has not immunized for this, after here you pass here then that was properly integrated.*"[168]

## Affordability

*a. Fees*

All services, tests and medicines in hospitals are supposed to be free of charge, according to most respondents.[169] However, many respondents have reported having to pay a small registration fee of 200

[160] SSI_WAP_16_OTH3, SSI_WAP_15_LM

[161] SSI_WAP_07_CHW1

[162] SSI_CEQ_15_LM

[163] SSI_CEQ_08_TL2, SSI_CEQ_06_BHC1, SSI_CEQ_HFW, SSI_CEQ_02_20F

[164] SSI_CEQ_12_ONGO, SSI_CEQ_06_BHC2

[165] KII_WAP_01_HPF, KII_WAP_02_SHO, KII_WEQ_01_HPF, KII_WEQ_02_SHO, SSI_CEQ_06_BHC2, SSI_CEQ_07_CHW2, SSI_WAP_07_CHW1, SSI_WAP_12_ONGO, SSI_WAP_16_OTH3, SSI_CEQ_05_HFW, SSI_CEQ_16_OTH3

[166] SSI_WAP_05_HFW

[167] KII_WEQ_01_HPF

[168] KII_WAP_01_HPF, KII_WAP_02_SHO,

[169] SSI_WEQ_06_BHC1, SSI_WEQ_07_CHW1

pounds and in some instances, they were asked to pay other fees for testing.[170] In Western Equatoria, these fees were said to be needed in order to purchase "*the book*" or the "*prescription book*", without which one cannot be seen by a doctor. Some respondents said that even though this amount seems very small, some people are just not able to pay for it and will be turned away as a result.[171] Other respondents, however, did say that care was completely free. The discrepancy in statements is likely due to some respondents having excluded the registration fee from their estimation of the cost of care. In Central Equatoria, a number of respondents said that school children being treated during school hours would receive free care, and that people who were referred to the health facility by the school would also receive free care.[172] When asked if there was any community-based health-insurance system, all respondents across all states said there were no such systems in place.

In Warrap, however, the situation was a bit different. One traditional leader interviewed there said, "*I have never seen someone treated for free.*"[173] In the hospital in Kuajok (in Warrap) a cost-sharing scheme is being applied, whereby patients are being asked to pay someone for the care they are receiving. An implementing partner stated that they have tried to find out who instituted this system, as care in the facility is supposed to be free of charge.[174] In some cases, fees were said to have prevented people from seeking care. Aside from this, most respondents in Warrap said they were being charged between 20 and 100 SSP for services at health facilities.[175] One respondent said, "*I don't know why 50 is being paid but if you don't pay you won't be attended to or registered even […] if you fail to get 50, then you will be a dead man so it is better you look for 50 to go to the hospital and later you will be referred to the clinic and clinic price is a goat price.*"[176]

*b. Consequences of fees*

Across all states, respondents spoke of the dire effects of fees on members of the population who are not able to pay. Patients have resorted to traditional medicines and herbs when they are unable to get the services or drugs they need. One respondent said, "*People drink these herbal medicines and they do not know whether it is treating their sicknesses or even causing more problems to them. For example, […] there was a day I drunk this [traditional medicine] and it caused problem to my uterus. Recently, there was a person who drunk this herbal medicine called ''Sawa- Sawa'' and the person died; it was not his interest to take the medicine, but because of poverty that is why he took the drug and something horrible happened.*"[177]

*c. Proceeds of fees*

[170] SSI_WEQ_16_OTH1, SSI_WEQ_02_20F, FGD_WEQ_04_20M, SSI_CEQ_03_15M

[171] FGD_WEQ_04_20M, FGD_WEQ_03_15M

[172] FGD_CEQ_08_HPW

[173] SSI_WAP_08_TL1

[174] SSI_WAP_11_IP

[175] SSI_WAP_16_OTH2, KII_WAP_01_HPF

[176] FGD_WAP_04_20M

[177] FGD_CEQ_05_PWL

Many respondents said that they did not know what the fees they were being charged were being used for. Other respondents said that they thought these fees were used to clean the hospital and purchase mops and brooms as well as soap.[178] One traditional leader in Central Equatoria said he saw the money being used for chairs and fans once.[179] In Warrap, where fees are consistently charged, an implementing partner said that they were told the fees were being used to pay staff who are not on the government payroll. However, that implementing partner investigated and found that there were ultimately no clear records of how the money was being spent.[180] Another respondent said that fees in his area were being used to "*fix the gap,*" meaning that if a piece of equipment was missing or the salary of a support staff-person had gone unpaid, that fee money would be used to make the necessary purchase or to pay the unpaid salary.[181]

Despite the free services and drugs that hospitals are supposed to provide, hospitals have serious problems with stock-outages, as mentioned above, so free tests and drugs are often unavailable, and patients are sent to private clinics or pharmacies where they must purchase those services.[182] Consultation fees and prices of drugs at private clinics were reported to be too high for a majority of South Sudanese people to pay. Respondents said that people do die as a result of not being able to access necessary care.[183]

Indirect costs associated with seeking healthcare primarily relate to transportation. This is a problem reported frequently by those living far away from urban centres and those living with disabilities.[184] High transportation costs were emphasised as a problem by those living with disabilities since they were also being overcharged by vehicle drivers as they need to help physically carry them into the facility or they need to be held and carried on the boda-boda.[185]

### Regional variations

The quality of care across the three areas covered by the study resembled each other, with difficulty in finding transportation to facilities, shortage of drugs, in particular, but also equipment and skills, moderate levels of satisfaction with the acceptability of the services and consistent reporting of having to pay fees. Despite these similarities, a few differences are worth pointing out.

In terms of acceptability of care in relation to interaction with medical staff, the respondents in Western Equatoria (Bazungua health facility, in particular) were overwhelmingly positive about the doctors and

[178] SSI_WEQ_09_PGO, SSI_CEQ_06_BHC2

[179] SSI_CEQ_08_TL1

[180] SSI_WAP_11_IP

[181] SSI_WAP_16_OTH3

[182] SSI, WEQ_16_OTH1, SSI_WEQ_10_CHD

[183] SSI_WEQ_08_TL2

[184] SSI_WEQ_07_CHW1

[185] SSI_WEQ_13_PWL, FGD_WEQ_06_CHD, SSI_WEQ_11_IP

nurses, saying they were well-liked in their communities and worked hard to help people. Those in Warrap and Central Equatoria reported many more negative issues in this respect. Respondents in Western Equatoria were also the ones that, more generally, say their facilities were clean, albeit cramped, while those in Central Equatoria complained most about the lack of cleanliness of their facility.

In terms of availability of drugs, equipment and skill, respondents in Warrap had overall negative perceptions of the current situation in comparison to how their facility was when it was being supported by MSF. During MSF days, they stated, there was not as much of a shortage of equipment and tests. On the other hand, those in Central Equatoria said that their current situation is considerably better than it used to, with more functional facilities, available services as well as drugs.

Finally, although many respondents across states mentioned the need to pay fees for various services, those in Warrap consistently reported having been charged at multiple stages during the care process while those in the other states primarily spoke of an initial 200 South Sudan pound registration fee.

## Community Health Workers

### Role

Respondents were asked about the specific role of community health workers, their relationship with health facility workers as well as the role of the Boma Health Committee. It should be noted that respondents used the terms "*community health workers*" and "*boma health workers*" interchangeably.

The Boma Health Initiative was a set up by the government with the help of HPF to reach areas and communities that would otherwise not have access to health workers or facilities. A state health official said that the community health workers are posted to areas more than five kilometres away from health facilities, so as to reach those who are least likely to have access to health care.[186]

The four main areas in which community health workers play a role in are:

*a. Health education*

Community health workers have a role in raising awareness of the importance of antenatal care and immunisation for young children.[187] It was reported that community health workers are responsible for awareness raising among pregnant women on the importance of prenatal care and referring them to the nearest facility.[188] Community health workers also raise awareness within their target communities about how community members can protect themselves against common diseases, or when there is an outbreak of a disease, and what to do if they contract a disease.[189] In recent months prior to being

[186] KII_WAP_02_SHO

[187] SSI_CEQ_10_CHD

[188] FGD_WAP_09_CHW, SSI_WEQ_07_CHW2

[189] SSI_CEQ_01_15F, SSI_CEQ_02_20F

interviewed, most community health workers were informed about the presence of COVID-19 and what to do to prevent the spread of the disease. One respondent also said that community health workers help to raise awareness about GBV, specifically domestic abuse, as well as the problem of molestation of children.[190]
Finally, community health workers are responsible for informing people where to receive free health services, so as to ensure that the inability to pay does not become a barrier to access.[191]

*b. Treatment*

Community health workers are trained to provide basic treatment for key diseases. One implementing partner specified that the workers have been trained "*to provide basic treatment to children who present with malaria, at least within 24 hours, children who present with diarrhoea and respiratory tract infections are given this treatment at the community level just to provide early treatment for this condition. If the child does not respond well, then they will make a referral.*"[192]

*c. Referral*

One respondent summarised the role of the community health as: "*There are two things that the Boma health workers do: one is to give awareness to the community through mobilisation and sensitising the population; and the second thing is to treat the diseases that infect people in the community, but if the diseases cannot be treated, they refer to the PHCC for better management, these are the roles of boma health workers.*"[193]

*d. Nutrition*

Community health workers screen children for malnutrition and send serious cases to the health facilities. [194] If such health workers come across a very ill person, they say they call the ambulance for the sick person to take them to the hospital.[195] Each worker is also in charge of following up with HIV patients and children in the nutrition programme, to make sure they are caring for themselves or are being cared for correctly.

Community members interviewed said that community health workers come to the homes and register all the children – recording their age, weight and height – and ask the mothers about the immunisation records of their children.[196] Health workers also carry basic medication with them to help provide in-

[190] SSI_WEQ_03_15M
[191] SSI_CEQ_07_CHW1
[192] SSI_CEQ_11_IP, SSI_WAP_07_CHW
[193] SSI_WAP_12_ONGO
[194] SSI_WAP_07_CHW2
[195] FGD_WAP_09_CHW
[196] FGD_WEQ_01_15F, SSI_CEQ_02_20F

home care for patients with non-serious conditions.[197] "*If the child falls sick at night they can give the medicine […] whenever the child falls sick they give syrup and malaria drug.*"[198]

### Perceptions on CHW effectiveness

Respondents were overwhelmingly positive in regard to the role played by these community health workers in their communities. Respondents spoke positively of the impact of the initiative to put community health workers in place, saying that previously far fewer people had access to care, especially those living in remote areas.[199] Community members described the community health workers as being cooperative, helpful and well-trained.[200] One respondent praised community health workers as compassionate, explaining that when community health workers see people in pain they do whatever they can to provide people with access to the needed care.[201]

The main complaint lodged by community health care workers is that their salaries are too low and are often paid late, with some community health care workers going unpaid for upwards of 6 months.[202] Community health workers also complained of the fact that, they are under-supplied, given the number of households in communities that they actually end up serving. In practical terms, community health workers often serve at least 60 households (or even 2 to 3 villages), but they are only given medicines and supplies to cover the 40 households they are officially responsible for covering.[203] Other challenges that health care workers face include lack of access to certain areas due to insecurity, flooding or lack of transport.[204] Community health workers in Gogrial West were given bicycles by an organization to carry out their work, however this still leaves certain remote areas out of their reach.[205] Community health workers also reported that they sometimes also need spare parts to repair their bicycles but they are typically not provided with parts.[206]

Respondents suggested that community health workers do not always have the training and capacities that they will need in order to be able to do their jobs well. One community health worker interviewed said that some community health workers have no background in medicine and are given a five-day training and are then sent out to administer treatment for some diseases (malaria, pneumonia, diarrhoea); it was suggested that more training be given.[207] Others more generally spoke of the lack of

[197] FGD_WEQ_03_15M, SSI_WAP_3_15M

[198] SSI_WAP_02_20F

[199] SSI_WEQ_11_IP, SSI_WAP_03_15M

[200] SSI_WEQ_08_TL2, SSI_WAP_16, OTH2

[201] SSI_WEQ_01_15F

[202] FGD_CEQ_09_CHW, FGD_WAP_09_CHW

[203] FGD_WAP_09_CHW

[204] SSI_CEQ_16_OTH2, SSI_WAP_12_ONGO

[205] SSI_WAP_06_BHC2, SSI_WAP_16_OTH2, SSI_WEQ_11_IP

[206] SSI_WAP_16_OTH2

[207] SSI_WEQ_07_CHW1

skills and lack of qualified people in the area.[208] Another respondent suggested that fundamental literacy can also be a barrier to community health workers being able to perform their roles well.

Respondents were also asked about the nature of the relationship between the community health workers and those working in the health facility. An implementing partner said that the community health workers come to nearby health facilities to restock their supplies and to update the facility about any unusual diseases or conditions in the community.[209]

A respondent from the county health department reported that the community health workers have strong ties with the facility because they provide the health facilities with reports about health conditions in the community and they refer patients to the health facilities in case of an emergency.[210] Community health workers interviewed also said they have a good relationship with the facilities that they are tied to, as they go there to get medicines and conduct meetings together.[211]

### Knowledge of, and perceptions on Boma Health Committees

Finally, respondents were asked about the Boma Health Committees; people are aware of them but very few people knew what their specific role was. One health worker who did understand their role described the Boma Health Committee as "*the one that supervising those of health personnel at the health facility level because there is no trust by the way people who will work there, they will put some drug in their pocket, so they are working seriously our selection is the one that can lead a boma health committee is the executive chief or paramount chief of that area is the one leading boma health committee. So, we are selecting paramount chief of that village so that he will be over all supervising the health facility in case of any health personnel that does not come on time will be given a warning or can even report to us so that we can see how we can handle it.*"[212] Health facility workers stealing and selling drugs on the market, "*to be able to pay for their families*", since salaries are so low, was mentioned by a number of respondents as an issue the health sector faces. A HPF respondent described the BHC's role like this, "*they have good collaboration, they have continuous meetings, they do meetings every month… like for example when medicines come, they are there to witness that medicines have arrived, they also bring reports from their Boma…various Boma. They come with the report and give it to the facility, and they also oversee some things that are happening in the facility.*"[213]

[208] KII_WAP_01_HPF
[209] SSI_CEQ_11_IP
[210] SSI_CEQ_10_CHD
[211] FGD_WEQ_09_CHW
[212] SSI_WAP_16_OTH2
[213] KII_WEQ_01_HPF

## Feedback mechanisms

Respondents were asked about mechanisms through which patients and others visiting the health care facilities could provide feedback about the services they received. Respondents were also asked about the effectiveness of the mechanisms in place for responding to such feedback. Although respondents suggested that mechanisms do exist and that community members are generally aware of how to report concerns, most interviewees also agreed that (in their experience) little meaningful action is ever taken as a result of the feedback process.

### Mechanisms as portrayed by those working in the sector.

Health care workers interviewed for this study primarily said that seeing happy patients is their primary metric for knowing whether or not their work is satisfactory. When a patient receives repeated treatment and his or her condition improves, health care workers take this as a sign that they are doing a good job.[214] Health care workers interviewed also mentioned the direct feedback they receive from patients who thank them for doing their jobs well.[215] One health care worker said, "*then the person will start explaining to you 'one time I took my child to hospital. The child was seriously sick, you treated my child very well and now my child is feeling good.'*"[216] Health care workers also suggested that when patients pay repeated visits to the same facility, this is a way of showing satisfaction with the care they received at that facility.[217]

Health care workers and other interviewees working directly in the health sector mentioned that there is a Boma Health Committee in each community that is meant to receive feedback and forward it to the health facilities in question and/or to the Ministry of Health.[218] These health committees are then supposed to report back to the community and let them know how complaints are being addressed by the ministry.[219] Another health facility worker also said complaints could be directed to the Boma Health committees who forward them to the health authority in the area.[220] A Boma Health Committee member complained, however, that there is often no action taken to address any of the grievances they forward. He explained: "*But I am here for four years. We can raise the problems but there is no feedback to the community. We have our minutes of the meetings CHD, Healthlink and the Ministry of Health will check the minutes, but there are no actions taken to address the grievances.*"[221]

[214] SSI_WEQ_06_BHC1

[215] SSI_WEQ_10_CHD

[216] SSI_CEQ_05_HFW

[217] SSI_WEQ_02_SHO

[218] FGD_CEQ_06_CHD, FGD_CEQ_07_BHC, FGD_WEQ_08_HFW

[219] FGD_CEQ_07_BHC, FGD_CEQ_08_HFW

[220] SSI_WAP_05_HFW, SSI_WAP_07_CHW1

[221] FGD_CEQ_07_BHC

An HPF respondent mentioned all the ways in which the community can provide feedback. The respondent said that HPF staff have monthly meetings with community leaders and members, so they are able to receive feedback on their programming from communities. HPF staff interviewed said that implementing partners talk to patients as they leave facilities to get a sense of their level of satisfaction. The HPF staff person also said some hospitals have suggestion boxes for collecting patient feedback.[222] Another NGO said they also have suggestion boxes at the facilities in their community and that they write up the suggestions provided through this mechanism in their monthly reports to the donor. This NGO staff-person who was interviewed also said they do interviews with various people in the community to get feedback from patients.[223]

A couple of respondents suggested that feedback can be provided through the radio. As one respondent explained, *"[…] through the radio and the media; we have the health programme like on Monday, so when you bring the health programme, yes, they can call and give us the feedback and tell us how exactly they have been done in their various communities, and how the health facility is working or operating."*[224]

### Mechanisms as understood by community members

The majority of community members interviewed (who had accessed healthcare facilities) said they spoke to community leaders when they had complaints about a health facility.[225] Women in Central Equatoria said they would talk to the "*president of women*" in their area.[226] Some mentioned that the church can help advocate on their behalf as well.[227] Young men in Central Equatoria said they would go to the office of the "*quarter council and youth*" in the area.[228]

The Quarter Council in Central Equatoria was mentioned by a number of respondents as the primary place for community members to raise grievances. "*The Quarter Council will listen to the grievances of the people, not only about health issues, [but] about every problem in the community like insecurity, robbery and gangs in the area. Then members of the city council will forward the grievances to Quarter Council. The Quarter Council itself is the parliament of the area."*[229] Other community members who were interviewed said they would go directly to the hospital or facility manager/director to report issues or go to the organizations funding the facilities and speak to them about the problems.[230]

[222] KII_WAP_01_HPF
[223] SSI_WAP_12_ONGO
[224] SSI_CEQ_15_LM
[225] FGD_CEQ_01_15F, FGD_CEQ_04_20M, FGD_CEQ_05_PLW
[226] FGD_CEQ_02_20F
[227] FGD_WEQ_07_BHC
[228] FGD_CEQ_03_15M
[229] FGD_CEQ_09_CHW
[230] FGD_CEQ_01_15F, FGD_CEQ_03_15M, FGD_WEQ_07_BHC

Traditional leaders interviewed in this study said that they closely follow up on those who are sick in their communities. Leaders said that they visit people's homes when those people return from extended stays in the hospital to ask how they are doing. Leaders explained that they use these informal visits as a means of gathering feedback from community members about the care they had received.[231]

Despite the existence of the formal and informal mechanisms detailed above, community members suggested that many people do not file complaints at all for fear of angering doctors or health care workers, and fear of not being cared for in the future or even being "*beat up*" for complaining.[232] One respondent said that doctors refuse to listen to "*those that are not educat[ed],*" that they do not feel like they need to listen to or are accountable to community members.[233] Other respondents suggested that their complaints and feedback have been conveyed and then totally ignored, no matter what mechanism was used.[234]

The interviewees living with disabilities complained that, because they are disabled, their concerns and feedback have been totally ignored.[235] One respondent with a disability explained: "*no one is listening to us people who are disabled because they do not consider us as people. Even [if] we write it down or write it on paper, nobody who can bother to read and do something about it.*"[236]

## Health Pooled Fund

### Perceived strengths of HPF

Interviewees were asked to give their opinion of Health Pool Funded (HFP) programming and respondents who knew of the HPF had a lot of positive remarks to make about how HPF programmes have improved health care access in their communities. Respondents repeatedly mentioned the drastic improvement in maternal health and child health services, claiming these services have led to very low maternal mortality and higher rates of child immunisation.[237] The HPF programme was also credited with training and connecting community health workers to the health care facilities through the Boma health initiative.[238] This Boma health initiative has sent community health workers to villages and they have brought these populations basic drugs such as treatment for children under five who have malaria or pneumonia, and care to pregnant women and the elderly, or has helped refer them to health facilities if

[231] SSI_CEQ_08_TL1

[232] FGD_WEQ_01_15F, SSI_WEQ_14_CSO

[233] FGD_WEQ_01_15F

[234] FGD_WEQ_05_PWL

[235] FGD_WEQ_05_PWL

[236] WEQ_05_PWL

[237] SSI_WEQ_16_OTH3, SSI_WEQ_16_OTH2, SSI_WEQ_16_OTH1, SSI_WAP_10_CHD, FGD_WEQ_07_BHC

[238] SSI_WEQ_16_OTH3, SSI_WEQ_14_CSO, SSI_WAP_10_CHD

necessary.[239] The rate of malaria infections were also said to have been reduced through the support of HPF.[240]

Respondents mentioned other support provided to their health facilities through HPF programming – namely, more medicines, stipends/incentives for the personnel, and training to health care workers.[241] HPF has also reportedly supported coronavirus screening sites and provided masks for staff. In terms of infrastructure, they have built latrines, incinerators, and waste management facilities.[242] It was reported that HPF has provided ambulances to some facilities.[243]

### Perceived shortcomings of HPF

Three main shortcomings were reported with HPF programming. The first was the lack of necessary and sufficient drugs, the second was the low incentives provided to health care workers, and the third was the manner in which HPF support was distributed to some facilities and not others.

The issue of insufficient drugs was brought up by a large majority of respondents across states.[244] Respondents lamented the fact that drugs are not being supplied according to the monthly reports health care providers prepare, which accurately reflect the reality of demand on certain drugs. Instead, a "*push system*" is being used, whereby certain drugs are provided by HPF in certain quantities on a quarterly basis with little to no input from those receiving them. [245] For example, anti-malarial drugs and those to treat pneumonia and diarrhoeas, the most common health problems in the area, are those most needed, but they are not receiving anywhere near the supply they need to meet demands.[246] Injectable drugs for malaria and other illnesses are not being provided at all.[247] Valium was another drug mentioned as absolutely crucial to have for emergencies to stop seizures, but they are not receiving them at all.[248]

The decrease in dollar amount of stipends provided to the staff in HPF3 as compared to earlier rounds was mentioned by a large number of respondents.[249] One respondent said, "*nurses who on the HPF2 were getting good money, were getting very good money, then with HPF3 now all is deducted; the clinical officers, for example were getting $400-600, now this time the clinical officers have got 300, 400-300 USD or so.*"[250] The general dissatisfaction of health care workers were directly correlated to a number of

[239] SSI_WAP_06_BHC1, SSI_WEQ_12_ONGO
[240] SSI_WAP_06_BHC2
[241] SSI_WAP_16_OTH2, SSI_WAP_12_ONGO, SSI_WAP_10_CHD, SSI_CEQ_06_BHC1, FGD_WEQ_06_CHD
[242] KII_WAP_02_SHO, FGD_WEQ_06_CHD
[243] SSI_WEQ_10_CHD, FGD_WAP_02_20F
[244] SSI_WAP_07_CHW2, SSI_WAP_05_HFW
[245] FGD_WAP_06_CHD
[246] FGD_WAP_06_CHD
[247] SSI_CEQ_10_CHD
[248] SSI_CEQ_10_CHD
[249] FGD_WEQ_06_CHD, FGD_WAP_12_ONGO
[250] SSI_WEQ_10_CHD

issues people were facing in the health facilities- doctors arriving late or leaving early and long wait times, overworked and unfriendly staff as well as lack of 24 hour coverage for emergencies. [251]

Also, some respondents spoke about the lack of transparency in the hiring process in the subsequent iterations of HPF programming. "*During the HPF 1, the recruitment process was 100% perfect. But for now, there is no board for recruitment like in HPF1, which is also affecting health service delivery, which is also additional.*"[252] Potential nepotism in the recruitment process was also identified by some respondents. [253]

Respondents spoke of the gap in quality of care in HPF-supported facilities and those facilities not supported by HPF.[254] Certain health facilities were dropped in this latest HPF programme and respondents did not believe the assessment to determine which facility to support or not were done carefully or with enough triangulation of information.[255] In Western Equatoria, one respondent was disappointed that only 12 facilities were supported this round, a number of facilities from previous rounds had been dropped.[256]

One respondent blamed all the HPF-related problems described above on the increased involvement of the South Sudanese government in HPF programming. Initially, HPF was working more independently and was getting input from the community. Now, however, the approach has become a top-down approach (according to this respondent) with limited consultation with the community.[257]

## VI. Conclusion

The purpose of the study was to investigate access to and utilisation of health care services in the counties supported by the HPF programme to enable identification of priority areas for reducing morbidity, disability, and mortality in South Sudan. The most common health problems were due to communicable diseases like malaria, typhoid, pneumonia, and diarrhoea. Other illnesses that were frequently mentioned were HIV and other sexually transmitted diseases, skin diseases, and stomach-related problems such as ulcers and worms.

The health care seeking behaviours were mainly driven by the availability of drugs and the affordability of treatment. Other factors that influenced respondents' decision to visit health facilities were the distance to the health facilities, courteous health workers, short waiting times and hygiene of health facilities.

[251] SSI_WAP_16_OTH2, FGD_WEQ_04_20M, FGD_WAP_06_CHD, SSI_WEQ_05_HFW, SSI_WEQ_03_15M, SSI_CEQ_10_CHD
[252] FGD_WEQ_06_CHD
[253] SSI_CEQ_12_ONGO
[254] SSI_WEQ_11_IP, SSI_WEQ_10_CHD
[255] SSI_CEQ_14_CSO
[256] SSI_WEQ_11_IP
[257] SSI_CEQ_14_CSO

Physical accessibility of health care centres was limited in many areas by long distances. This was exacerbated in many areas due to poor road infrastructure and seasonal flooding and was particularly acute for vulnerable groups such as pregnant women, people living with disabilities or people too ill to move around on their own. The short supply of drugs, equipment and personnel were major concerns for respondents since they led to delays in treatment and pushed patients towards private clinics/pharmacies and/or traditional healers.

The acceptability of services, affected by long waiting times, negative interactions between patients and health workers, and bad infrastructure as points of concern. Health workers were, however, positive about the technical quality of health facilities, with updated registers and guidelines and integrated services. Care was largely viewed as affordable despite the registration fees that most respondents had to pay, although some respondents did report that these fees did push them towards seeking traditional medicine. In some health care facilities, clients needed to pay informal/unexpected fees for medicines. These costs were said to have an impact on patients' ability to access care.

The community health workers played a pivotal role in health education, basic treatment, and malnutrition monitoring within communities, as well as referral to health facilities when further treatment is required. CHWs were generally highly valued by both communities and health facilities and are key in raising awareness at the grass roots level on health issues ranging from family planning, immunisation, and coronavirus. However, they were faced with many challenges in implementation due to a lack of funding and transport in remote areas. Health facilities are said to offer a wide range of services such as antenatal services, and immunisation, HIV, and malnutrition programmes, but people are not always aware of the health services being provided. Health messaging comes from sources such as community leaders, Boma Health Committees, schools, and radio.

Finally, people living with disabilities were found to be worse off in every aspect. They felt discriminated in their general treatment by health workers, but particularly during coronavirus pandemic when health workers were reluctant to provide them with physical help. People living with disabilities' access to health care facilities is more limited than others because the extra support they need when traveling comes at a price and health facilities do not have the adequate infrastructure to accommodate them. Channels of health information was not catered to their needs and limitations, and their feedback was often ignored due to their disabilities.

## VII. Recommendations

The findings give rise to a number of recommendations to improve access to healthcare in a broad sense. The following are suggestions for improvement at different levels, touching upon the responsibilities of Health Pooled Fund and the Ministry of Health down to implementing partners, county health departments and health facility workers.

a) Improve the drug supply and include more commodities on the current list of HPF drugs. Some additional drugs like diazepam for treatment convulsions should also be considered for inclusion on the current list. Drug availability and insufficiency of supply was mentioned as highly influential in the respondents' health seeking behaviours. We further recommend taking steps to ensure that

the drugs supply to the health facilities is more based on the demand and consumption data instead, moving away from the current 'push' system of drug supply to the facilities. This consequently requires further strengthening of the use of DHIS2 and the registration of drug consumption data.

b) Improve the timeliness and regularity of the remuneration of health workers. Although the HPF pays incentives to some health workers, there those who are dependent on the government salaries only. The respondents indicated that some behaviour exhibited by the health workers is probably driven by low and delayed payment of their salaries. Unpaid salaries seem to be at the root of many other key problems-such as patients being charged a fee to receive care, unmotivated and rude staff who come late, leave early, or do not show up at all. In light of the recent standardisation and rationalisation of incentive scales it is probably not feasible to review these scales. However, a need remains to pay specific attention to the timeliness and regularity of salary and incentive payments provided to health facility workers and community health workers.

c) Consider increasing the number of health facilities supported by the programme so that remote communities are in closer proximity of the facilities. This will reduce the burden of travelling long distances given that transportation costs coupled with poor road infrastructure, especially in the rural and remote areas form barriers to health care access. Therefore, the programme should work with the CHD and SMoH to ensure that the facilities that are supported are well distributed across the counties and payams.

d) There is need to consider adapting the number and type of staff in the health facilities to conform with the BPHNS. Many respondents mentioned a shortage of health personnel and skills, that creates long waiting times and the need to transfer patients to other health facilities when certain skills are unavailable. Even for personnel who are available, government salaries are reported to be months late or not paid at all. Some support staff are not on the payroll and are not being paid a formal salary at all.

e) Consider increasing the number of ambulances and transport facilities in the health facilities to reduce access barriers, including those related to referrals. Those ambulances that are in poor mechanical conditions should be repaired or replaced to enable them to facilitate referrals of patients in need of emergency care or people living with disabilities.

f) There is an urgent need to better consider the needs of people living with disabilities in terms of their health in broad terms and their rights as citizens. This ranges from sensitising health workers and health authorities to the impact of stigma(tisation) on their lives, more respectful, dignified and responsive healthcare practices for people living with disabilities and their rights as equal citizens, to concretely adapting infrastructure in health facilities to make them more physically accessible for people living with disabilities.

g) Some facilities require infrastructure improvements in the areas of water, sanitation, and electricity/lighting to enable them to operate more optimally, and around the clock (24/7). For

example, in Central Equatoria the respondents suggested to install solar panels in some sections of the facilities such as the maternity ward to make them accessible to the mothers during the night.

h) Improve communication, responsiveness, and accountability between health workers, health authorities and citizens/communities. Although a number of feedback mechanisms seem to be available to communities/patients and they are aware of some or most of them, there is a need to build a feedback mechanism into the health system, since many community members mentioned that they did not see any evidence of their suggestions or concerns being addressed.

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# IX. Appendices

## Appendix 1 - Overview of study participants including unique identifiers (UIDs)

| METHOD | PARTICIPANT | TYPE | WARRAP | WESTERN EQUATORIA | CENTRAL EQUATORIA | TOTAL PARTICIPANTS |
|---|---|---|---|---|---|---|
| **KEY INFORMANT INTERVIEWS (KIIS)** | HPF State representatives | KI | KII_WAP_01_HPF | KII_WEQ_01_HPF | KII_CEQ_01_HPF | 3 |
| | State Health Officials | KI | KII_WAP_02_SHO | KII_WEQ_02_SHO | KII_CEQ_02_SHO | 3 |
| **Subtotal # participants** | | | **2** | **2** | **2** | **6** |
| **SEMI-STRUCTURED INTERVIEWS (SSIs)** | Late adolescent girls (15-19 years) | SP | SSI_WAP_01_15F | SSI_WEQ_01_15F | SSI_CEQ_01_15F | 3 |
| | Adult women (20 years and above) | SP | SSI_WAP_02_20F | SSI_WEQ_02_20F | SSI_CEQ_02_20F | 3 |
| | Late adolescent boys (15-19 years) | SP | SSI_WAP_03_15M | SSI_WEQ_03_15M | SSI_CEQ_03_15M | 3 |
| | Adult men (20 years and above) | SP | SSI_WAP_04_20M | SSI_WEQ_04_20M | SSI_CEQ_04_20M | 3 |
| | Health facility workers | KS | SSI_WAP_05_HFW | SSI_WEQ_05_HFW | SSI_CEQ_05_HFW | 3 |
| | Boma, village or health facility committee | KS | SSI_WAP_06_BHC1 | SSI_WEQ_06_BHC1 | SSI_CEQ_06_BHC1 | 3 |
| | Boma, village or health facility committee | KS | SSI_WAP_06_BHC2 | SSI_WEQ_06_BHC2 | SSI_CEQ_06_BHC2 | 3 |
| | Boma/community health workers | KS | SSI_WAP_07_CHW1 | SSI_WEQ_07_CHW1 | SSI_CEQ_07_CHW1 | 3 |
| | Boma/community health workers | KS | SSI_WAP_07_CHW2 | SSI_WEQ_07_CHW2 | SSI_CEQ_07_CHW2 | 3 |
| | Traditional authority (boma or village) | KS | SSI_WAP_08_TL1 | SSI_WEQ_08_TL1 | SSI_CEQ_08_TL1 | 3 |
| | Traditional authority (boma or village) | KS | SSI_WAP_08_TL2 | SSI_WEQ_08_TL2 | SSI_CEQ_08_TL2 | |
| | Payam government official | KS | SSI_WAP_09_PGO | SSI_WEQ_09_PGO | SSI_CEQ_09_PGO | 3 |
| | County health department officials | KS | SSI_WAP_10_CHD | SSI_WEQ_10_CHD | SSI_CEQ_10_CHD | 3 |
| | Implementing partner (NGO) | KS | SSI_WAP_11_IP | SSI_WEQ_11_IP | SSI_CEQ_11_IP | 3 |
| | Other health NGOs (humanitarian or other) in area | KS | SSI_WAP_12_ONGO | SSI_WEQ_12_ONGO | SSI_CEQ_12_ONGO | 3 |
| | Persons living with disability | SP | SSI_WAP_13_PWL | SSI_WEQ_13_PWL | SSI_CEQ_13_PWL | 3 |
| | Civil society/faith-based organization (CSO/FBO) | KS | SSI_WAP_14_CSO | SSI_WEQ_14_CSO | SSI_CEQ_14_CSO | 3 |
| | Local media | KS | SSI_WAP_15_LM | SSI_WEQ_15_LM | SSI_CEQ_15_LM | 3 |
| | Others (through snowballing) | KS | SSI_WAP_16_OTH1 | SSI_WEQ_16_OTH1 | SSI_CEQ_16_OTH1 | 3 |
| | Others (through snowballing) | KS | SSI_WAP_16_OTH2 | SSI_WEQ_16_OTH2 | SSI_CEQ_16_OTH2 | 3 |
| | Others (through snowballing) | KS | SSI_WAP_16_OTH3 | SSI_WEQ_16_OTH3 | SSI_CEQ_16_OTH3 | 3 |
| **Subtotal # participants** | | | **21** | **21** | **21** | **63** |
| **FOCUS GROUP DISCUSSIONS (FGDs)** | Late adolescent girls (15 - 19 years) | SP | FGD_WAP_01_15F | FGD_WEQ_01_15F | FGD_CEQ_01_15F | 3 FGDs (6-8 participants each) |
| | Adult women (20 years and above) | SP | FGD_WAP_02_20F | FGD_WEQ_02_20F | FGD_CEQ_02_20F | 3 FGDs (6-8 participants each) |
| | Late adolescent boys (15-19 years) | SP | FGD_WAP_03_15M | FGD_WEQ_03_15M | FGD_CEQ_03_15M | 3 FGDs (6-8 participants each) |
| | Adult men (20 years and above) | SP | FGD_WAP_04_20M | FGD_WEQ_04_20M | FGD_CEQ_04_20M | 3 FGDs (6-8 participants each) |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Citizens with disabilities (men and women) | SP | FGD_WAP_05_PWL | FGD_WEQ_05_PWL | FGD_CEQ_05_PWL | 3 FGDs (6-8 participants each) |
| | County health department officials | KS | FGD_WAP_06_CHD | FGD_WEQ_06_CHD | FGD_CEQ_06_CHD | 3 FGDs (6-8 participants each) |
| | Boma health committee/health committee members | KS | FGD_WAP_07_BHC | FGD_WEQ_07_BHC | FGD_CEQ_07_BHC | 3 FGDs (6-8 participants each) |
| | Health facility workers | KS | FGD_WAP_08_HFW | FGD_WEQ_08_HFW | FGD_CEQ_08_HFW | 3 FGDs (6-8 participants each) |
| | Boma health workers/community health workers | KS | FGD_WAP_09_CHW | FGD_WEQ_09_CHW | FGD_CEQ_09_CHW | 3 FGDs (6-8 participants each) |
| **Minimum subtotal # participants** | | | **9 FGDs** | **9 FGDs** | **9 FGDs** | **27 FGDs (6-8 participants each)** |
| **TOTAL # OF PARTICIPANTS** | | | **77** | **77** | **77** | **231** |

## Appendix 2 – Generic topic guide for SSIs with Key Stakeholders

Interviews will be used to explore views on barriers to access and quality, initiatives for improvement and community participation and empowerment. Key stakeholders include:

- HPF state coordinators/representatives
- State health officials
- County health department officials
- Payam government officials
- Traditional authorities at the boma and village levels
- Health facility management committee members
- Boma health committee members
- Health facility workers
- Community health workers
- NGO (not necessarily related to HPF)
- CSO (not necessarily related to HPF)
- FBO (not necessarily related to HPF)
- Media representatives (not necessarily related to HPF)

*The interviewer should read the following information to the person being interviewed:*
*"Thank you for agreeing to participate in our interview. We will be asking you some questions about your role in health care, your perceptions on the health needs in the communities you work with, and your perceptions on barriers to access to care and challenges related to quality of care. This interview will take about 45-60 minutes. In order for me to capture as much of what you tell me as possible, I will be recording this interview with your permission, so that no information is lost as you speak."*

*Before we begin, please let me know if you have any questions. If not, we can start the interview.*

| **AREA OF INQUIRY** | **GUIDING QUESTIONS** | **PROBING** |
|---|---|---|
| **1. Introduction** | What is your role in your organization/place of work? | |
| **2. Most prevalent health care needs within communities.**<br>*Now I would like to talk to you about the health care needs of this area, as well as HPF's role in addressing those needs.* | | |
| 2a**.** Prevalent health needs and service provision | What are the three most common health problems in the county/catchment area? | Are there differences in the most common health problems between:<br><br>1. The general population vs. women of reproductive age? If yes, what are the unique health problems of women of reproductive age? |

| | | |
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| | | 2. The general population vs. adolescents? If yes, what are the unique health problems of adolescents? |
| | What health services are provided in relation to the most common problems? | Probe for whether or not the following services are provided and to whom:<br><br>• Antenatal care<br>• Delivery<br>• Postnatal care<br>• Family Planning<br>• CCC comprehensive care clinic – HIV TB)<br>• Immunisation<br>• Other |
| | Who provides these services? | Examples:<br><br>• HPF- supported facilities<br>• CHW/BHW<br>• Other primary care facilities and hospitals<br>• Private clinics |
| | Where do the community members seek treatment when they or their dependents fall sick? | Do they go to HPF-supported facilities or use other facilities? Why? |
| | What did you observe in community members' reactions to COVID-19? How does/did it affect people's decisions to visit health facilities? | |
| | What is your opinion on the role of the community health workers/Boma health workers in your area? | |
| | What are the working relationships between community health workers and the health facilities in your community? | |
| **3. Healthcare seeking behaviors, (barriers, preferences) regarding primary care in the catchment population**<br><br>*Now I would like to talk to you about a number of elements that influence whether or not people use primary healthcare.* | | |

| | | |
|---|---|---|
| 3a. Provision of information | What/who are the main sources of information for the population about primary care facilities and the services they provide? | Examples of main sources:<br>• Radio?<br>• Leaflets?<br>• Community awareness activities?<br><br>Who shares this information?<br>• Chiefs?<br>• Boma health teams?<br>• Village health teams?<br>• Boma health workers?<br>• Community health workers?<br>• Others? |
| | What are the main challenges that communities face in gaining access to information on health services? | Do boma health workers face any unique challenges that are different from the challenges you just mentioned? |
| | Could you tell me about the initiatives undertaken in the county/area to inform people about COVID-19? | What information, by whom? |
| 3b. Approachability and acceptability of the primary care facilities and the community health workers/Boma health workers | People have choices on whether to visit health facilities, when and how. What do you think attracts people to health facilities? | Leave this as a completely open question and allow the interviewee to respond fully before moving to the more targeted questions below. |
| | What do you think keeps people away from health facilities? | Leave this as a completely open question and allow the interviewee to respond fully before moving to the more targeted questions below. |
| | Only ask the following questions if the discussion around the open-ended questions above was not informative in terms of telling us how the respondents feel about the approachability and acceptability of facilities and health workers.<br><br>DO NOT ASK THESE QUESTIONS OF HEALTH FACILITY WORKERS OR COMMUNITY HEALTH WORKERS. | |
| | • Have you ever witnessed or personally experienced any of the following scenarios at health facilities in your area?<br>(1) A health care worker was not friendly while a patient was seeking care.<br>(2) A health care worker did not speak the same language as the patient. | • If yes, for each: Please describe what you witnessed. How frequently do you think this is actually a problem in your area? Why? |

| | | |
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| | (3) A health care worker did not explain the patient's diagnosis and treatment.<br>(4) A health care worker did not give the patient the possibility to ask questions. | |
| | • Have you ever witnessed or personally experienced any of the following scenarios at health facilities in your area?<br>(1) A health care provider was not trusted by people in your area.<br>(2) A health care provider or health facility had a bad reputation in your area. | • What influenced this distrust? What do *trusted* healthcare workers do differently? How does COVID-19 influence trust in health care? If yes, for reputation: Why did they gain a poor reputation? What do providers or facilities that have a good reputation do differently? |
| | | |
| 3d. Availability and accommodation (access) | How do people usually access their preferred health facility? | |
| | What is, according to you, the most important challenge to the availability of health services? | Examples:<br>• Physical access in terms of distance and availability/affordability of transport<br>• Waiting times<br>• Drugs and supplies<br>• Health workers |
| | What is your opinion about the availability of drugs and supplies in the health facilities? Is there a difference between facilities in availability of drugs? | What are the reasons for drug stockouts?<br>• Late delivery?<br>• Pilferage and private market in drugs?<br>How frequently is this a problem in your area? |
| 3e. Affordability | Almost two-thirds of funds for healthcare in South Sudan come from private households (out-of-pocket).<br>When visiting not-for-profit health facilities do people ever need to pay for anything?<br>• Please explain why or why not.<br>• If yes, do you know why these costs are charged and | Potential probes:<br>• Does the need to pay differ depending on the service?<br>• What types of payments are they? Formal vs informal payments.<br>• Is the money ever used for cost recovery or extortion? In other words, is the fee revenue retained by facilities or shared/passed on to higher |

| | | |
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| | what happens with this revenue?<br>• If yes, how much do people typically need to pay for the most common services? | authorities? How frequently is this a problem?<br>• Are there any conflicts of interest /corruption, such as pilferage of drugs to sell privately? How frequently is this a problem? |
| | Is there any system for fee exemption or coverage (not having to pay)? | Examples:<br>• Community-based insurance arrangements<br>• Charity<br>• Exemption policies<br><br>How does this work? |
| | Are there any other indirect costs that are incurred in the process of getting the services? If so, what are they? | Examples:<br>• Transport costs<br>• Separate payment for drugs<br>• Loss of income because of skipping work when seeking care |
| **4. Perceived and realized quality of health care of the HPF health facilities by the community, facility staff, community health workers/Boma health workers, and patients.**<br>*Lastly, I would like to discuss with you the quality of health care at HPF-supported health facilities.* | | |
| 4a. Quality of health services | Have community health workers/Boma health workers received training?<br><br>How would you evaluate the effectiveness of the training they have received? | |
| | **(For HPF health providers and health committees)** How would you evaluate the quality of this health facility's infrastructure? By infrastructure, we mean buildings, power source (solar, generator, etc.), water and sanitation facilities (pit latrine/toilet, waste disposal bins, incinerator, etc.), and transport means (ambulance, motorbike, etc.)<br><br>**(For non-HPF stakeholders)** How would you evaluate the quality of infrastructure at health facilities in this area? | |
| | **(For HPF health providers and health committees** | |

| | | |
|---|---|---|
| | How would you describe the state of this facility's registers, tools, or forms for managing patients/clients?<br><br>**(For non-HPF stakeholders)**<br>How would you describe the state of the registers, tools, or forms used at health facilities in this area to manage patients/clients? | |
| | **(For HPF health providers and health committees)**<br>How would you describe the state of this facility's safety protocols/procedures, if there are any?<br><br>**(For non-HPF stakeholders)**<br>How would you describe the state of the safety protocols/procedures (if any) used at health facilities in this area to manage patients/clients? | E.g. around containers for disposal of needles, waste, etc. |
| 4b. Quality of services (process elements) facility level | **(For HPF health providers and health committees)**<br>What are your perceptions on the treatment guidelines that are in place for health workers to follow at this health facility?<br><br>**(For non-HPF stakeholders)**<br>What are your perceptions on the treatment guidelines that are in place for health workers to follow at health facilities in this area? | To what extent are treatment guidelines followed by health workers? |
| | **(For HPF health providers and health committees)**<br>How would you evaluate the process for prescribing medicines at this health facility?<br><br>**(For non-HPF stakeholders)**<br>How would you evaluate the process for prescribing medicines at the health facilities in this area? | |
| | **(For HPF health providers and health committees)** | |

| | | |
|---|---|---|
| | What is your opinion on the protocols for handling emergency cases at this health facility?<br><br>**(For non-HPF stakeholders)**<br>What is your opinion on the protocols for handling emergency cases at health facilities in this area? | |
| | **(For HPF health providers and health committees)**<br>How would you evaluate this facility's process for integrating services where integration is appropriate and needed?<br><br>**(For non-HPF stakeholders)**<br>For health facilities in this area, how would you evaluate the process for integrating services where integration is appropriate and needed? | By integration, we mean 'one stop visits' e.g. tuberculosis (TB) and HIV; missed opportunities for expanded programme on immunisation (EPI), antenatal care (ANC) and family planning (FP) |
| | **(For HPF health providers and health committees)**<br>What are your thoughts on the wait times for consultations at this health facility?<br><br>**(For non-HPF stakeholders)**<br>What are your thoughts on the wait times for consultations at health facilities in this area? | |
| | How would you describe the level of functionality of health facilities and Boma health committees in this area? | |
| 4d. Citizen feedback | How is patient satisfaction measured, if at all? | |
| | How, if at all, can citizens provide feedback to the facility? For example, how could a citizen express their concerns over access to the facility or quality of care? | |
| **5. HPF Programme** | **(Filter question for groups not necessarily related to HPF)**<br><br>Are you familiar with the HPF programme?<br><br>**IF YES, PROCEED WITH QUESTIONS.** | |

| | | |
|---|---|---|
| | **IF NO, SKIP TO END.** | |
| | How do the services offered by HPF-supported facilities address the key health issues in the catchment area? | How is this decided? Who participates in deciding this? |
| | How were health facilities and bomas selected to be supported by HPF? Was there a needs assessment conducted? | Are the activities of the health facilities still consistent with the original goal of HPF programme? |
| | Now I would like to ask you about your general perceptions on the outcomes of the HPF programme. What effect has the HPF programme had on health outcomes and social life in your area? | Do you see other positive or negative effects of the HPF programme? |

## Appendix 3 – Generic topic guide for SSIs with Study Populations

- Late adolescent girls (15-19 years)
- Adult women (20 years or older)
- Late adolescent boys (15-19 years)
- Adult men (20 years or older)
- Persons living with disability

Interviews with these groups will be used to explore their views on key citizens' concerns around access to and perceived quality of care. They will give insights about barriers, preferences when seeking care as well as knowledge and awareness about primary health care services offered by the health facilities and through the Boma health initiative.
*The interviewer should read the following information to the person being interviewed:*

*"Thank you for agreeing to participate in our interview. We will be asking you some questions about your experiences with health care, your perceptions on the health needs in the community, and your perceptions on barriers to access to care and challenges related to quality of care. This interview will take about 45-60 minutes. In order for me to capture as much of what you tell me as possible, I will be recording this interview with your permission, so that no information is lost as you speak."*

*Before we begin, please let me know if you have any questions. If not, we can start the interview.*

| **AREA OF INQUIRY** | **GUIDING QUESTIONS** | **PROBING** |
|---|---|---|
| **1. Introduction** | Could you tell me about your most recent experience with health care? | Use of particular services; exposed to sensitization; met with CHW or health worker<br><br>Where was it? |

| | | |
|---|---|---|
| | How often have you visited a health facility in the past year? | |
| | How often have you interacted with a community health workers/Boma health worker in the past year? | |
| | How often do you think young women/women/young men/men/people with disabilities* like you visit a health facility? | |
| **2. Most prevalent health care needs within communities** | | |
| 2a. Prevalent **health needs** of the communities in the catchment areas of health facilities supported by HPF in South Sudan | What do you think are the three most common health problems in this area for young women/women/young men/men/people with disabilities*? | |
| | Where do young women/women/young men/men/people with disabilities* seek treatment when they or their dependents fall sick? | Examples:<br>• Informal facilities<br>• HPF-supported facilities,<br>• Community health workers/Boma health worker<br>• Other primary care facilities and hospital<br>• Private clinics<br><br>Have you ever been there?<br><br>Have you ever used the services? Why/Why not? |
| 2b. Knowledge about services provided | What is the nearest health facility?<br><br>Do you know what services are provided at the nearest health facility? If yes, what are they? | Probe for these services:<br><br>• Antenatal care<br>• Delivery<br>• Postnatal care<br>• Family Planning<br>• Comprehensive care clinic (CCC) – HIV/TB)<br>• Immunisation<br>• Other |
| | What role do community health workers/Boma health workers play in your community? | |
| **3. Healthcare seeking behaviours, (barriers, preferences) regarding primary care in the catchment population** | | |
| 3a. General assessment as introduction | People have choices on whether to visit health facilities, when and | Leave this as a completely open question and allow the |

| | | |
|---|---|---|
| | how. What do you think attracts young women/women/young men/men/people with disabilities* to health facilities? | interviewee to respond fully, probing for additions, before moving to the more targeted questions below. |
| | What do you think makes young women/women/young men/men/people with disabilities* stay away from health facilities? | |
| | Only ask the following questions if the discussion around the open-ended questions above was not informative in terms of telling us how the respondents feel about the approachability and acceptability of facilities and health workers. | |
| | Have you ever witnessed or personally experienced any of the following scenarios at health facilities in your area?<br><br>• A health care worker was not friendly while you were seeking care.<br>• A health care worker did not speak the same language as you.<br>• A health care worker did not explain your diagnosis and treatment.<br>• A health care worker did not give you the possibility to ask questions. | If yes, for each:<br><br>• Please describe what you experienced and how it made you feel.<br>• How frequently have you experienced this issue? |
| | Have you ever witnessed or personally experienced any of the following scenarios at health facilities in your area?<br><br>• A health care provider was not trusted by young women/women/young men/men/people with disabilities* in your area<br>• A health care provider or health facility had a bad reputation among in your area | If yes, for trust:<br><br>• What influenced this distrust?<br>• What do *trusted* healthcare workers do differently?<br>• How does COVID-19 influence trust in healthcare?<br><br>If yes, for reputation:<br>• Why did they gain a poor reputation?<br>• What do providers or facilities that have a good reputation do differently? |
| | Have you ever witnessed or personally experienced any of the following scenarios at health facilities in your area? | If yes, for each:<br><br>• Please describe what you witnessed. |

| | | |
|---|---|---|
| | • A health facility did not have the essential health commodities available in sufficient quantities to cover the young women/women/young men/men/people with disabilities* in your area (e.g. drugs, vaccines)<br>• A health facility did not have the essential equipment and diagnostics available for the common health problems of young women/women/young men/men/people with disabilities*<br>• A health facility did not have skilled staff or enough staff for offering services to young women/women/young men/men/people with disabilities* | • How frequently do you think this is actually a problem in your area? Why? |
| | | |
| 3b. Access to information | How did you learn about the primary health care facilities and services in the area? | Examples:<br>• Radio?<br>• Leaflets?<br>• Community awareness activities?<br><br>Who shares this information?<br>• Chiefs?<br>• Boma health teams?<br>• Village health teams?<br>• Boma health workers?<br>• Others? |
| | What would you like to know more about regarding health/illness, services, work of Boma health workers? | |
| | Have you heard about the COVID-19 pandemic? Can you describe what it is?<br><br>If yes, where did you get the information from? | |
| | What would be <u>your</u> preferred information source about health services? | Examples:<br>• Radio?<br>• Leaflets? |

| | | |
|---|---|---|
| | | • Community awareness activities?<br><br>Who shares this information?<br>• Chiefs?<br>• Boma health teams?<br>• Village health teams?<br>• Boma health workers?<br>• Others? |
| 3e. Availability and accommodation (access) | How do you travel to your preferred health facility? How much time does it take? | Probe: Think about last time used.<br><br>• Distance<br>• Travel time<br>• Mode: by foot, bike, donkey, car, bus? |
| | What barriers do young women/women/young men/men/people with disabilities* face in travelling to healthcare facilities in your area? | Distance/access to nearest vs most appropriate facility (maybe hospital services, PHCC, or PHCU with appropriate services are too far) |
| | What are the typical opening and closing hours of a health facility in your area? How do young women/women/young men/men/people with disabilities* generally feel about those opening hours? | Suitable opening hours or not, when is it closed?<br><br>Average waiting time. |
| | What are the typical waiting times? How do young women/women/young men/men/people with disabilities* generally feel about those waiting hours? | Reasons for waiting |
| | Where do people in this area go for medication?<br><br>What is your opinion about the availability of drugs and supplies in the health facilities? | Reasons for drug stockouts.<br><br>Late delivery?<br><br>Pilferage and private market in drugs? |
| 3f. Affordability | Do <u>you</u> remember what you spent on accessing health services the last time you visited a health facility, if anything? Was this at a private/for-profit facility or a public/not-for-profit facility? | Probe for different services<br>And costs (transport, consultation etc.) |

| | | |
|---|---|---|
| | When visiting not-for-profit/public health facilities do people need to pay for anything? Can you explain? | Formal vs informal payments. Any sign of drug pilferage (drugs stolen from public facilities and sold privately)? |
| | Do you know why costs are charged and what happens with this revenue? | Cost recovery or extortion? Is the fee revenue retained by facilities or shared/passed on to higher authorities? |
| | If so, can you specify how much people typically need to pay for the most common services? | |
| | Is there any system for people not having to pay (fee exemption free health care? | Community-based insurance arrangements, charity, exemption policies<br><br>How does this work? |
| | How do you generate the means to pay for these costs? | Probe: from regular income, savings, loans (from whom, with or without interest, how much), selling (productive) assets (which assets)? |
| | Does this have an effect on your general livelihood? What about other young women/women/young men/men/people with disabilities* in your area? | How do these costs affect you? Do you have examples? |
| **4. Perceived quality of health care of the HPF health facilities**<br>*We just talked about aspects of access to care, now I would like to ask your opinion about the quality of care.* | | |
| | Let us now review some of the issues just discussed. I am going to mention a number of factors that influence people's experience at a health facility and whether they like to return. For each of those, please tell me how satisfied people generally are at the nearest health facility. Not satisfied – 1, Satisfied – 2, Very satisfied - 3<br>• Respectful and dignified treatment<br>• Availability of equipment and supplies<br>• Availability of drugs<br>• Privacy<br>• Friendliness<br>• Opening times<br>• Waiting times | |

| | | |
|---|---|---|
| | • Affordability<br>• Non-discrimination<br>• Confidentiality | |
| | How satisfied do you think people are generally about these aspects in your area? | |
| | Are different groups of young women/women/young men/men/people with disabilities receiving the same quality of care? | People with different wealth status, professions, gender, ethnicity, religion, age, sexual orientation etc.? |
| | How do people share their opinions and experiences about quality of care? | Do they express poor experiences? Good experiences? How? Which channels are used? |

## Appendix 4 – Generic topic guide for FGDs with Key Stakeholders

FGDs will be used to get in-depth exploration of access including health seeking behaviours regarding the primary care within the catchment areas of the various HPF supported health facilities and boma health workers. The FGDs will allow the team to have insights on contrasting issues, enrich preliminary findings and discuss recommendations. Key stakeholders who will participate include:

- Health facility workers
- The county health department officials
- Boma health committee/health facility committee members
- Boma health workers/community health workers

*NOTE:*

- The FGD involves exercises to get to an agreed set of issues and recommendations on improving access and quality of services.

*The moderator should read the following information to the group:*

*"Thank you for agreeing to participate in our group discussion. We will be asking you some questions about your role in health care, your perceptions on the health needs in the communities you work with, and your perceptions on barriers to access to care and challenges related to quality of care. This discussion will take about 90 minutes. In order for me to capture as much of what you tell me as possible, I will be recording this discussion with your permission, so that no information is lost as you speak."*

*Before we begin, please let me know if you have any questions. If not, we can start the discussion.*

| **AREA OF INQUIRY** | **GUIDING QUESTIONS** | **PROBING** |
|---|---|---|
| **1. Introduction**<br>Use cards and prepare IDs | Age range<br>Gender<br>Participant code | |
| **2. Most prevalent health care needs within communities falling within the catchment areas of HPF3 funded health facilities in South Sudan** | | |
| 2a. Prevalent health needs | What are, according to you, the three most common health problems in this area? Are they different for *women, men, young men, young women? | |
| | What are, according to you, the main challenges health facilities and health workers face in responding to these challenges? | |
| 2b. Evolution of provision of health services | Evolution of the provision of health services: have you noticed changes in the provision of health services in recent years? | Regarding: more services, other services, improvement of services? |
| | To your knowledge, has the HPF programme brought about any changes to your work, health outcomes and social life in your area? (either positive or negative) | Regarding: more services, other services, improvement of services? |

| | | |
|---|---|---|
| | What have been recent developments and challenges in the health sector in this payam/area as a result of COVID-19? | |
| **3. Access** | How do people usually access their preferred health facility? | |
| | What barriers do young women/women/young men/men/people with disabilities* face in travelling to healthcare facilities in your area? | |
| | How long does that take for them? | Distance and travel time. By foot, bike, donkey, car, bus, etc. |
| | Do the opening and waiting times of/at the health facility suit people? Can you explain? | Suitable opening hours or not, when is it closed? Average waiting time. |
| | If not, what do you think is the reason for this? | Reasons for waiting |
| **4. Quality** | What are characteristics of a "good" health centre?<br><br>Ask the group to select two themes to discuss:<br>- Probe for examples<br>- Note agreement<br>- Note disagreement | Probe: what makes people visit a certain health facility? When is a health facility attractive for people to visit? Probe: add, agree, disagree.<br><br>Probe for issues on respect, health worker behaviour, costs (including informal costs), treatment |
| **5. Availability** | How would you evaluate the availability of drugs and supplies at health facilities in your area? | |
| **6. Affordability** | How would you evaluate the affordability of health care at health facilities in your area? | |
| **7. Community participation** | Is there a way that patients can give advice or feedback to the health facility or CHW to improve their services?<br>How does that happen? How often? | |
| **4. Recommendations** | | |
| Formulating recommendations to improve access and quality (20 mins) | Think about the different issues on access and quality we just discussed: what are your suggestions to improve access? What are your suggestions to improve quality? | Go beyond participants listing wishes and investments, probe into two themes more in-depth. |

## Appendix 5 – Generic topic guide for FGDs with Study Populations

FGDs will be used to get in-depth exploration of access including health seeking behaviours regarding the primary care within the catchment areas of the various HPF supported health facilities and boma health workers. The FGDs will allow the team to have insights on contrasting issues, enrich preliminary findings and discuss recommendations. Community members who will participate include:

- Late adolescent girls (15-19 years)
- Adult women (20 years or older)
- Late adolescent boys (15-19 years)
- Adult men (20 years or older)
- Persons living with disability

*NOTE:*

- The FGD involves exercises to get to an agreed set of issues and recommendations on improving access and quality of services.

*The moderator should read the following information to the group:*

*"Thank you for agreeing to participate in our group discussion. We will be asking you some questions about your experiences with health care, your perceptions on the health needs in the community, and your perceptions on barriers to access to care and challenges related to quality of care. This discussion will take about 90 minutes. In order for me to capture as much of what you tell me as possible, I will be recording this discussion with your permission, so that no information is lost as you speak."*

*Before we begin, please let me know if you have any questions. If not, we can start the discussion.*

| AREA OF INQUIRY | GUIDING QUESTIONS | PROBING |
|---|---|---|
| **1. Introduction**<br>Use cards and prepare IDs | Age range<br>Gender<br>Participant code<br>Marital status | |
| **2. Most prevalent health care needs within communities (15 mins)** | | |
| 2a. Health problems | What are, according to you, the three most common health problems in this area for young women/women/young men/men/people with disabilities* in the county/catchment area? | |
| 2b. Health seeking choices, health facility options | If *young women/women/young men/men/people with disabilities* in this area are faced with such health problems, where do they seek care? | Probing to get picture of type of facilities/CHW visited by this particular group |
| 2c. Access to information | • How do you and other *women, men, young men, young women know about the types of health services that you can find in this area?<br>• What would you like to know more about? | |

| | | |
|---|---|---|
| | • Have you heard about the COVID-19 pandemic? How? What do you think about the virus? Are people visiting health facilities during the pandemic? | |
| 2d. Evolution of provision of health services | Evolution of the provision of health services: have you noticed changes in the provision of health services in recent years? | Regarding: more services, other services, improvement of services? |
| | Who among you is familiar with the HPF programme? What effect has the HPF programme had on health outcomes and social life in your area? | |
| **3. Access** | How do people usually access their preferred health facility? | |
| | How long does that take for them? | Distance and travel time. By foot, bike, donkey, car, bus, etc. |
| | Do the opening and waiting times of/at the health facility suit people? Can you explain? | Suitable opening hours or not, when is it closed? Average waiting time. |
| **4. Quality** | - What are characteristics of a "good" health centre?<br>- Do you think these issues are particularly important for *women, men, young men, young women?<br><br>Ask the group to select two themes to discuss:<br>- Probe for examples<br>- Note agreement<br>- Note disagreement | Probe: what makes you visit a certain health facility? When is a health facility attractive for you to visit? Probe: add, agree, disagree.<br><br>Probe for issues on respect, health worker behaviour, costs (including informal costs), treatment |
| **5. Participation** | Is there a way that you or *young women/women/young men/men/people with disabilities* can give advice or feedback to the health facility or CHW to improve their services?<br><br>When you or *young women/women/young men/men/people with disabilities* encounter challenges to access health services or when they are not satisfied with the health services provided, is there a way they can express their concerns? With whom? | |
| **6. Recommendations** | | |

| | | |
|---|---|---|
| Formulating recommendations to improve access and quality (20 mins) | Think about the different health facilities in your area and the issues we just discussed: what makes young women/women/young men/men/people with disabilities* want to visit them more for better health?<br><br>- Start with two selected themes (10 mins)<br>What are your suggestions for health facilities or health programmes in your area to improve the services for *young women/women/young men/men/people with disabilities* | |

## Appendix 6 – Codebook for data analysis

| **Code Group: Common health problems (6 codes)** |
|---|
| *CHP_Children (12 and under)* |
| *CHP_Women* |
| *CHP_Men* |
| *CHP_General* |
| *CHP_Adolescents (13-17)* |
| *CHP_Elderly* |
| *CHP_Disabilities:* This is for passages in which common health problems including diseases and symptoms for people living with disabilities is mentioned, it seems in that FGD they are discussing the health problems particular to them |

| **Code Group: Health seeking behaviour (5 codes)** |
|---|
| *HSB_when_yes*: use for passages describing in what circumstances individuals seek medical assistance Ex: example of when they last sought medical attention |
| *HSB_when_no*: use for passages describing in what circumstances individuals refuse to seek medical assistance |
| *HSB_where:* use for passages describing where people go to seek medical assistance (hospitals, free clinics, private clinics etc..) |
| *HSB_Corona_changes*: use for passages describing how/if health seeking behaviour has changed due to Coronavirus |
| *HSB_characteristics:* use for passages describing the characteristics that individuals seek for in health care facilities, or the characteristics of a good health care centre |

| **Health Facility Worker (repeat for community health worker, CHW) (9 codes)** |
|---|
| *HFW_role:* use for passages describing the work of health care workers. Do not use to code opinions of positive/negative perceptions of their work, only use to code descriptive/factual statements of their role within the community<br>CHW_role (same as above but with community health workers)<br>BHC_role (same as above but for Boma health committee) |
| *HFW_strength:* use for positive opinions/perceptions of health facility workers, their relationship with the communities, their reputations, and their work<br>CHW_strength: (same as above) |
| *HFW_barrier* use for negative opinions of health care workers, their relationship with the communities, their reputations and their work<br>CHW_barrier (same as above) |
| *HFW-CHW_relationship:* use on passages describing the relationship (both negative and positive) between the health workers working in hospitals and other facilities and the community health workers |
| *HFW/CHW_training:* use on passages describing training received by HFW or CHW and their perception of the quality of that training |

| **Code group: Information sources (6 codes)** |
|---|
| *IS_source:* use for passages describing where people get their information (facts), not opinions on their effectiveness |

| |
|---|
| *IS_preferred_source*: use for passages in which respondents describe preferred information source and why they prefer it |
| *IS_barrier*: use for passages describing challenges in accessing/passing on medical information |
| *IS_strength*: use for passages describing how accessing/passing on medical information has been done well |
| *IS_corona*: use for passages describing how information about Coronavirus has been shared |
| *IS_health_knowlege:* this is to code passages when people speak of their health knowledge, for example if they say "coughing and fever are signs of Corona virus" this is their knowledge of health issues. Also covered by this code are community norms (for example, she said that the PLD said that the community doesn't greet disabled people anymore since Corona) so the community's and individual's knowledge/perception of health issues are to be coded with this code |

| **Code group: Availability (7 codes)** |
|---|
| *AV_awareness:* use on passages describing people's perception/knowledge/awareness of health services available in their communities and how they address common health problems |
| *AV_equipment:* use on passages describing the availability of equipment at health care facilities |
| *AV_skills:* use on passages describing the availability of skills/ specialized doctors (etc..) at health care facilities |
| *AV_drugs/treatment:* use on passages describing the availability of specific drugs or treatment (etc..) at health care facilities |
| *AV_barrier:* use on passages describing people's negative evaluation of availability of health services in their communties |
| *AV_strength:* use on passages describing people's negative evaluation of availability of health services in their communties |
| *AV_changes:* use on passages describing changes over time in the availability of health services in communities |

| **Code group: Accessibility (3 codes)** |
|---|
| *ACC_physical:* use on passages in which respondents describe physical accessibility of the health care center in terms of distance and time it takes to get to it, modes of transport used, opening hours, etc… (factual statements not opinions) |
| *ACC_barrier:* use on passages where people negatively evaluate their access to health (opinions) |
| *ACC_strength:* use on passages where people positively evaluate their access to health (opinions) |

| **Code Group: Acceptability (7 codes)** |
|---|
| *ACCP_interaction_strength:* use on passages in which patient describes positively the interaction they have had with health care worker<br>Ex: short waiting time, health worker was respectful/kind, |
| *ACCP_interaction_barrier:* use on passages in which the patient negatively describes the interaction he/she has had with health care workers<br>Ex: feelings of discrimination, language barriers, lack of explanation of diagnosis/medicines prescribed |
| *ACCP_physical_barrier:* use on passages in which the physical space is evaluated negatively<br>EX: small, dirty space, waiting rooms overcrowded with nowhere to sit, curtains don't provide privacy |
| *ACCP_physical_strength:* use on passages positively describing state of the physical space |

| |
|---|
| Ex: large space, clean, privacy respected with doors/curtains, basic infrastructure in good working condition |
| *ACCP_services_strength:* use on passages in which the services (including registers, guidelines, protocols, and prescriptions) provided by a particular facility is positively evaluated |
| *ACCP_services_barrier:* use on passages in which the services (including registers, guidelines, protocols, and prescriptions) provided by a particular facility is negatively evaluated |
| *ACCP_recommendations:* this is for passages where respondents relay their wishes, requests, needs in terms of improving health services, interactions with HCWs, or physical spaces (when not specifically for HPF- we have a specific code for those suggestions specific to HPF) |

| **Code Group: Affordability (5 codes)** |
|---|
| AFF_fees: use on passages giving monetary values of specific medical services (fact) or passages mentioning the lack of a fee |
| AFF_fee_proceeds: use on passages describing what happens with the proceeds from out-of-pocket payments/what they are for (including any rent-seeking schemes/revenue shared with CHD/SMoH etc..) |
| AFF_ability_to_pay_barrier: use on passages describing instances where people were unable to pay, in which situations and for what reasons |
| AFF_ability_to_pay_strength: use on passages in which patients say fees are within their ability to pay, are not too high/are reasonable |
| AFF_inability_to_pay_effect: use on passages in which patients describe the effects of having had to pay high fees, including impoverishment/going into debt/selling productive assets |

| **Code Group: Equity (2 codes)** |
|---|
| *EQ_barrier*: Use on passages where respondents refer to unequal treatment of different groups; discrimination, poorer access, poor treatment by providers (include the passage where the group is described) |
| *EQ_strength*: Use on passages where respondents refer to equal treatment of different groups (include the passage where the group is described) |

| **Code Group: Providing Feedback (4 codes)** |
|---|
| *PF_content:* use on passages in which respondents describe the nature of their feedback/concerns (content) directly related to the PF mechanism |
| *PF_mechanism*: use on passages in which respondent describes the different mechanisms and channels by which feedback is shared (factual) |
| *PF_mechanisms_barrier*: use on passages in which respondent negatively describes the use of these mechanisms.<br>EX: if these mechanisms don't seem to work, if concerns/feedback is not heeded etc… |
| *PF_mechanisms_strength*: use on passages in which respondent positively describes the feedback mechanisms available, how they have seen them work, how/if feedback has led to concrete changes |

| **Code Group: Evaluating HPF (4 codes)** |
|---|
| *HPF_role:* use for passages describing the work, role or structuring of HPF. Do not use to code opinions of positive/negative perceptions of their work, only use to code descriptive/factual statements of their role |
| *HPF_strength*: respondents' positive perceptions of the impact of HPF programme |

| |
|---|
| *HPF_barrier*: respondents' negative perceptions of the impact of HPF programme |
| *HPF_recommendations:* for passages where respondents provide recommendations on how to change HPF programming |

| **Health facilities (30 codes) – use only for linking coded statements to specific HFs** | |
|---|---|
| *HF_Alek* | *HF_Kuwait* |
| *HF_Anet* | *HF_Magala* |
| *HF_Aweil* | *HF_Malakia* |
| *HF_Bazungua* | *HF_Maliul Ajak* |
| *HF_Bodo* | *HF_Mandeng* |
| *HF_Buluk* | *HF_Markazaran* |
| *HF_Custom* | *HF_Mayengumel* |
| *HF_Deng Jong* | *HF_Munuki* |
| *HF_Gogrial* | *HF_Naanzari* |
| *HF_Gurei* | *HF_Nyakuron* |
| *HF_Jebel Kujur* | *HF_Nzara* |
| *HF_Juba* | *HF_Osthra Tuna* |
| *HF_Juba teaching hospital* | *HF_Saba* |
| *HF_Kator* | *HF_Wau* |
| *HF_Kuajok* | *HF_Yambio* |

| **Additional codes (2 codes)** |
|---|
| *Unclear*: for passages that don't make sense |
| *Illustrative quote*: for all statements by participants that are surprising or explicit or interesting) |

*Note to coders*

- Keep coded segments to max 100 words (roughly).
- Often questions are framed at finding faults in healthcare skills/services, eg. have respondents ever experienced that HFWs do not explain the diagnosis. If the response is 'yes' it should be coded as a barrier; if the response is 'no' it should be coded as a strength.
- Break up the coding segments when there is a follow-up question and for FGDs, code each response separately.
- Barrier/strength codes should be used as overarching tags for negative/positive opinions, whether they are perceptions about CHWs or challenges/opportunities that they face.
- Code parts of the questions if/when response are yes/no or are not understandable when they stand alone.
  *Ex1: Do you have treatment for malaria in this hospital?*
  *R: Yes*
  *HERE PLEASE CODE THE ENTIRE SECTION: "IV_drugs/treatment".
  *EX2: Do you have treatment for malaria in this hospital?*
  *R: The hospital has all kids of medicines to treat malaria*
  *HERE ONLY CODE THE RESPONSE, NO NEED TO CODE THE QUESTION AS IT IS CLEAR AS A STAND-ALONE QUOTATION