A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

The State of Public Health in South Sudan

CRITICAL CONDITION

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THE STATE OF PUBLIC HEALTH IN SOUTH SUDAN
CRITICAL CONDITION

Richard Downie[1]

Overview

Less than 18 months into its life as an independent nation, South Sudan is facing a desperate struggle for survival. Because the terms of its separation from Sudan were not decided before independence, negotiations have dragged on over issues including borders, security arrangements, and the qualifications for citizenship, diverting attention from the urgent task of development. Most damagingly, the two nations have failed to cooperate on oil production, the mainstay of their economies. Anger over the high price Sudan was demanding to use its pipeline prompted the government of the Republic of South Sudan (GRSS) to shut off oil production entirely in January 2012. Although a compromise was reached in August, implementation stalled until a broader agreement was signed by the two countries in late September.

The implications for health development in South Sudan are stark. Even before the oil shutdown, international donors had paid for and delivered most health services. However, talks had been ongoing to transfer to a more sustainable system in which the GRSS assumed more responsibility for the health needs of its citizens. Donors spoke of the importance of moving away from a top-down system centered on emergency relief and primary health care delivery, mainly administered by international nongovernmental organizations (NGOs). Instead, the objective was to move to a new phase focused on developing health systems that would increasingly be managed by South Sudanese themselves. These plans were put on hold by the oil shutdown and the calamitous economic crisis it triggered. Donors feel that South Sudan has regressed in the period since independence, and they apportion a lot of the blame for the dire situation on the government of South Sudan.

The United States has played a critical role in delivering health services to the people of South Sudan and helping build nascent health institutions. The U.S. government has been a steadfast supporter of the Southern Sudanese since the darkest days of their civil war with the government in Khartoum, providing diplomatic, humanitarian, and technical support to the Sudan People's Liberation Movement/Army (SPLM/A), the guerilla force that has become the government of the nation. The United States is on course to give more than $1 billion in financial assistance to South Sudan in

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2011–2013.[2] Now is the time to start placing strict conditions on that support. The United States should make it clear that the number one responsibility of the GRSS is the welfare of its people. Although the United States will assist, it will not do so forever, and it will certainly not allow its support to enable bad decisionmaking by the government in Juba.

The current situation provides a chance for the United States to review its approach on public health in South Sudan. The economic crisis and the serious humanitarian situation on the border with Sudan mean that emergency relief will continue to constitute a large portion of U.S. health support. Expectations are being reset accordingly, but it will be important to retain a focus on the goal of long-term development. The United States, along with other donors, faces the difficulty of coming up with creative ways to build a sustainable health system in South Sudan while meeting the immediate health needs of its citizens. This process will involve challenging the culture of dependency in South Sudan and persuading the GRSS to take meaningful steps to turn its stated desire for ownership of its health system into reality. This is a difficult task to accomplish when the GRSS is collecting little to no revenue. But as preparations get under way to resume oil production, a conversation needs to take place, in coordination with other donors, which leads to a new partnership agreement with South Sudan. The agreement should be specific, spelling out targets for health service delivery and health worker training and placing dollar amounts on what the GRSS will be expected to contribute. It should also contain penalties for GRSS noncompliance, including the freezing of nonemergency assistance. A clear framework for continued support is essential, because failure to reset the bilateral relationship will come at a high price. It will impede the development of South Sudan, set back the public health agenda, and eventually exhaust the patience of U.S. taxpayers, who will begin to wonder why their continued generosity is failing to lead to concrete improvements in the lives of ordinary citizens.

Introduction

In January 2012, the GRSS took the drastic decision to halt oil production throughout the country. By shutting down its most important industry—the source of 98 percent of its revenue—the government hoped to extract a fairer deal from its northern neighbor, Sudan, whose pipeline is its only outlet for transporting and selling its oil. This act of brinkmanship had a catastrophic impact on the ability of the GRSS to fund essential services, including its health sector.[3] The donor community, which already provided the majority of health services in South Sudan, via international NGOs, was not consulted in advance of the decision and deeply resented the assumption that it would fill the

[2] "Undemocratic rule will lose S. Sudan US support, envoy says," *Sudan Tribune*, September 25, 2012, http://www.sudantribune.com/spip.php?article44002.

[3] The scale of the crisis was revealed in a leaked briefing by Marcelo Giugale, World Bank director of economic policy and poverty reduction programs for Africa, dated March 1, which describes the GRSS decision to shut down its oil as "shocking" and says he has "never seen a situation as dramatic as the one faced by South Sudan." He concludes that "state collapse" is a "real possibility."

yawning budget gap created by what it considered to be a reckless decision by the GRSS. Faith in the world's newest nation was further undermined when in April it launched a military incursion into what is generally viewed as Sudanese territory, occupying the North's most productive oil field before international pressure forced it to withdraw. Although Juba and Khartoum reached a tentative agreement in August on how to share the proceeds of their oil industry, neither side put pen to paper until the end of September. Even under the best-case scenario, oil production is not expected to resume fully until the summer of 2013, partly because of damage incurred to facilities during the military skirmishes.

At the same time, a massive humanitarian crisis has been unfolding in parts of South Sudan. Refugees have poured across the border from Sudan's provinces of Southern Kordofan and Blue Nile, where a conflict between government forces and rebels from the Sudan People's Liberation Army-North has been exacting a terrible toll on civilians. The refugee crisis comes hard on the heels of the latest episode in a deadly cycle of inter- and intra-ethnic fighting in South Sudan's largest state, Jonglei. Entire villages were razed to the ground, including the health facilities that served communities for many miles around. On top of these immediate humanitarian crises, much of the rest of South Sudan continues to struggle with chronic health needs linked to poverty, underdevelopment, and insecurity.

All of these events have forced the international community to review the terms of its relationship with the host government and rethink its strategy on health. The formula for engagement in fragile or post-conflict states, where an emergency relief phase transitions into a more sustainable development phase, has begun to look hopelessly irrelevant to conditions on the ground in South Sudan. Donors have switched gears, diverting development funds back into humanitarian assistance while trying to preserve ongoing efforts to build capacity within the nascent health system. At the same time, a consensus is emerging that humanitarian crisis will persist in South Sudan for some time to come and that, as a result, relief and development activities will have to be carried out in parallel for the foreseeable future. This paper seeks to take a broad look at the health situation in South Sudan, examine the challenges of dealing with a dysfunctional, and in some cases obstructive host government, and make some recommendations for how the United States can hope to maximize the value of its investments in South Sudan's health sector.

South Sudan's Health Emergency

South Sudan became the world's newest nation in July 2011, formally ending an independence struggle with Sudan that had led to Africa's longest civil war. The cost of 40 years of war cannot be calculated purely in terms of lives lost and homes destroyed. Successive generations missed out on formal education and had no opportunity to work and gain skills outside the guerilla army, the SPLA. Economic activity virtually ceased and development remained at a standstill. Millions of Southerners were displaced, many of them fleeing abroad. The Comprehensive Peace Agreement finally ended the war in 2005 and laid out a path to political transition, but the nation of South Sudan that emerged in 2011 bore the scars of decades of conflict, neglect, and poverty.

As a result, South Sudan poses a uniquely difficult development challenge. It endures continued insecurity both internally and externally. It faces multiple humanitarian emergencies, mostly in hard-to-reach areas. Infrastructure is virtually nonexistent outside the capital, Juba, and the larger state capitals. Its citizens are poor, unskilled, and searching for jobs that an undeveloped economy is unable to provide. Its government is weak, lacking in technical capacity, mired in corruption, and struggling to establish legitimacy in the eyes of its people.[4] In public health terms, these challenges add up to an enormous, largely unmet demand for health services.

For donors, including the United States, tackling South Sudan's health issues involves a combination of dealing with immediate humanitarian crises, often involving refugees, and the no less urgent task of providing basic health services to settled communities whose needs are often almost as desperate as those who have been displaced by conflict. The line between emergency relief and health development is often blurred in South Sudan. Health professionals working in South Sudan will say it is possible to do both relief and development at the same time, but this is difficult to operationalize given that the two roles are often carried out by different organizations, with the initial relief phase led by the likes of the Office of U.S. Foreign Disaster Assistance (OFDA) of the U.S. Agency for International Development (USAID) before a handover takes place to development professionals in other departments, once conditions stabilize. South Sudan's state of permanent crisis means that the handoff has never occurred. OFDA is now in its 20th year of operations in South Sudan, its longest program anywhere in the world. It has saved many lives in the process, but its work—which involves delivering emergency supplies as fast as possible over a short period of time—is by definition expensive and does not lend itself to sustainable development.

Amid the surge of optimism that greeted the independence of South Sudan, the GRSS and the donor community expressed confidence that humanitarian needs would gradually subside as the new nation slowly got on its feet. The opposite turned out to be the case. In the months following July 2011, serious outbreaks of fighting took place in Jonglei, Unity, and Upper Nile states, among others. The worst violence occurred in the opening weeks of 2012, when a resurgence of fighting between members of the Lou Nuer and Murle ethnic groups led to the deaths of nearly 900 people and prompted tens of thousands more to flee their homes.[5] The nearest hospital equipped to deal with the injured is in Akobo county, a five-hour boat ride from the worst of the fighting and the only facility in Jonglei state with an x-ray machine. The hospital, which is run by the relief organization International Medical Corps, treated 61 patients with gunshot wounds in March alone.[6] On top of

[4] Official corruption has become so serious that in June 2012, President Salva Kiir wrote to 75 current and former officials asking them to return a total of $4 billion of public money he said they had stolen.
[5] Hereward Holland, "Tribal Raids Killed 900 South Sudanese in Dec-Feb: UN," Reuters, June 25, 2012, http://www.reuters.com/article/2012/06/25/us-southsudan-killings-idUSBRE85O17D20120625.
[6] Interview conducted by author with Sean Casey, IMC country director, Juba, August 6, 2012.

the insecurity, a poor harvest in 2011 led to severe food shortages affecting populations in 5 of South Sudan's 10 states.[7]

The fragile internal security situation was compounded by the effects of the conflict in neighboring Sudan, which prompted civilians to flee Southern Kordofan and Blue Nile states. The refugees took up residence in makeshift camps in Upper Nile and Unity states. Humanitarian organizations struggled to cope with the influx, which had reached 170,000 by the end of July.[8] The remote location of the camps complicated efforts to deliver emergency assistance, and seasonal rains soon made them virtually inaccessible by land. The squalid, rain-soaked conditions were perfect vectors for the spread of waterborne disease. By August, the Office of the UN High Commissioner for Refugees was reporting that in the two largest camps, deaths among infants under the age of five were running at more than double the emergency threshold of four per day.[9] Disease and severe malnutrition combined to create health conditions described by several veteran aid workers as the worst they had encountered anywhere in the world. In addition, South Sudan was receiving a steady stream of returnees, people who had been displaced during the civil war but who now wished to resettle in the newly independent country. Their numbers had passed 400,000 by July 2012.[10] Many of them were destitute and required emergency assistance that the GRSS was unable to provide.

The austerity budget passed by the GRSS in the wake of the oil shutdown slashed total government expenditure to only $2.2 billion, sharply reducing the amount that could be spent on humanitarian relief. The international community has largely picked up the tab but in many cases has been forced to fill the gap with money that had been earmarked for development programs. The United States gave $205 million in emergency aid to South Sudan in the first seven months of 2012 alone.[11]

On top of its multiple humanitarian emergencies, South Sudan has to contend with a chronic public health crisis affecting the majority of the population. The lack of reliable health statistics makes it difficult to grasp the full scale of the problem, but the patchy data that are available paint a bleak picture. Maternal mortality rates are the highest in the world, with an estimated 2,050 deaths per 100,000 live births. This figure, combined with fertility rates, means that the average woman in South

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[7] USAID Famine Early Warning Systems Network, "South Sudan Food Security Outlook Update," August 2012, http://www.fews.net/docs/Publications/South_Sudan_FSOU_2012_08_final.pdf.
[8] UNOCHA, "Sudan Monthly Humanitarian Snapshot," July 31, 2012, http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA%20Sudan%20Humanitarian%20Snapshot_July%202012.pdf.
[9] UNHCR, "UNHCR describes alarming health and nutrition situation in South Sudan camps," news release, August 24, 2012, http://www.unhcr.org/503881659.html.
[10] USAID, "South Sudan–Complex Emergency: Fact Sheet #4, Fiscal Year 2012," July 17, 2012, http://transition.usaid.gov/our_work/humanitarian_assistance/disaster_assistance/countries/south_sudan/template/fs_sr/fy2012/south_sudan_ce_fs04_07-17-2012.pdf.
[11] UNOCHA, "South Sudan Humanitarian Funding Update," July 31, 2012, http://reliefweb.int/sites/reliefweb.int/files/resources/map_2810.pdf.

Sudan has a one in seven chance of dying during one of her pregnancies or childbirth.[12] Malaria is endemic in South Sudan, causing the deaths of an estimated 44,000 people per year. Tuberculosis affects approximately 228 per 100,000 people.[13] Children suffer particularly poor health. Approximately one-quarter of under-fives are stunted due to inadequate nutrition,[14] while only one in five children aged one year or under are immunized against measles.[15] As a consequence, South Sudan has the highest under-five mortality rate in the world, at 135 per 1,000 live births.[16] The majority of the population does not have access to clean water. Of the 17 Neglected Tropical Diseases (NTDs) recognized by the World Health Organization, all are present in South Sudan. They include Dracunculiasis, or guinea worm, which is spread through contaminated water. South Sudan had 99 percent of the world's documented cases of the disease in the first half of 2012.[17] HIV/AIDS rates are still fairly low, at an estimated 3 percent nationwide. However, the main provider of antiretroviral therapy, the Global Fund to Fight AIDS, Tuberculosis and Malaria, suspended new grant-making in 2011, meaning that newly diagnosed patients do not have access to drugs that could extend or save their lives.[18] Low levels of health awareness among the general public, along with rudimentary systems of disease surveillance and prevention, make it difficult to control disease outbreaks when they occur.

South Sudan's dire health outcomes are closely linked to a lack of access to health care. South Sudan has a total of 1,147 functioning health facilities serving a population believed to be in excess of 10.5 million.[19] This number includes just 37 hospitals.[20] More than half of the population lives more than a three-mile walk from the nearest Primary Health Care Unit (PHCU), the most basic health facility.[21] The per capita number of outpatient visits to health facilities is just 0.2 each year.[22]

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[12] UNDP, "South Sudan: Millennium Development Goals: Overview, #5: Improve Maternal Health," http://www.ss.undp.org/content/south_sudan/en/home/mdgoverview/overview/mdg5/.
[13] South Sudan Ministry of Health, "Basic Package of Health and Nutrition Services for Southern Sudan, final draft," January 2009, p. 19.
[14] South Sudan Ministry of Health, "Health Sector Development Plan, 2012-16, final draft," January 2012, p. 7.
[15] UK House of Commons International Development Committee, "South Sudan: Prospects for Peace and Development," April 2012, paragraph 35, http://www.publications.parliament.uk/pa/cm201012/cmselect/cmintdev/1570/157008.htm#a12.
[16] South Sudan Ministry of Health, "Basic Package of Health and Nutrition Services for Southern Sudan," p. 9.
[17] WHO Collaborating Center for Research, Training, and Eradication of Dracunculiasis, "Guinea Worm Wrap-Up #213," July 16, 2012, http://www.cartercenter.org/resources/pdfs/news/health_publications/guinea_worm/wrap-up/213.pdf.
[18] Andrew Green, "South Sudan HIV Treatment Hurt by Lack of Money," Voice of America, April 6, 2012, http://www.voanews.com/content/south-sudan-hiv-treatment-hurt-by-lack-of-money-146526755/180435.html.
[19] South Sudan Ministry of Health, "Health Sector Development Plan, 2012-16, final draft," p. 10.
[20] Ibid.
[21] Author interview with Dr. John Rumunu, director of Sudan Health Transformation Project, Phase II, Juba, August 10, 2012.
[22] South Sudan Ministry of Health, "Health Sector Development Plan, 2012–16, final draft," p. 10.

Buildings are ill-equipped and unhygienic, often consisting of no more than a one-room structure with thatched roof and dirt floor.

There is a chronic shortage of health professionals at all levels, from nurses and midwives to lab technicians, doctors, and surgeons. There are 1.5 doctors and 2 nurses for every 100,000 citizens.[23] The personnel gap is partially filled by less qualified staff, such as community health workers (CHWs) and home health promoters (HHPs), but they do not have the ability to deal with anything beyond the most routine cases. Despite the shortage of staff, the biggest U.S. health program in South Sudan, the USAID-funded Sudan Health Transformation Project (SHTP), does not support pre-service training, concentrating instead on in-service training. While improving the skills of existing health staff is critical, this approach does not expand the overall pool of available personnel. However, it is more sustainable given the fact that the GRSS cannot afford to pay the salaries of the existing labor force. Nearly half the people working in South Sudan's health service are employed by international NGOs. In addition, many NGOs top up the salaries of health workers on the government payroll, who receive lower wages.

The human capacity deficit extends to the planning, policy, and oversight functions of the health system. Sufficiently qualified staff are almost entirely absent from the County Health Departments (CHDs), and the situation is little better at either the State Ministries of Health (SMOH) or at the national Ministry of Health (MOH). Planning capacity is particularly weak, meaning that predictable seasonal outbreaks of diseases like malaria rapidly turn into full-blown health crises because stockpiles of drugs and mosquito nets are not ordered and distributed in advance. Capable and dedicated individuals are dotted across the health system, but they find themselves overburdened and unsupported or placed in settings where they are overseen by people less qualified than themselves. Demoralization can quickly set in, and as a result, staff retention is a problem.

South Sudan: A Problematic Partner

The events of the past 12 months or so in South Sudan, where a political deadlock over oil transport fees has coincided with a serious deterioration in the humanitarian situation, has reinforced the dependence of the GRSS on international donors, who continue to shoulder the main responsibility for delivering primary health care services and emergency assistance. In these circumstances, the task of promoting sustainable health care development in South Sudan is more difficult than ever.

At the same time, it is becoming increasingly difficult for donors to engage with South Sudan's government in an effective and constructive manner. Donors complain that the GRSS and the MOH demand ownership of the health system without accepting the responsibility that comes with it. Unlike their counterparts in other countries emerging from conflict, such as Liberia and Afghanistan, South Sudan's MOH asserts its desire to deliver health services in addition to performing the usual functions of a ministry, such as setting the policy agenda and providing a stewardship role. On the

[23] Ibid., p. 11.

one hand, it is understandable that the GRSS wishes to be seen to be delivering public services, given the challenges it faces in building state legitimacy in the eyes of its citizens. In addition, there is heartfelt resentment against donors for channeling their health delivery funding almost entirely through international NGOs and a feeling that the international community is failing to make sustainable investments in the country's health system despite all the money it has spent. The fact remains, however, that the GRSS is largely unwilling to pay for the health care of its citizens. Even before the oil shutdown, South Sudan's health system was 75 percent funded by the international community. While roughly 60 percent of the national budget is spent on salaries and security, a paltry 2.8 percent is spent on health. Rwanda, by comparison, devotes nearly 19 percent of its budget to health.[24]

The current approach of the GRSS boils down to a rhetorical commitment to pay for health services at an undetermined point in the future coupled with an expectation that the donor community will do so in the meantime. Even though it is not signing the checks, the GRSS demands full responsibility for how the money is spent and castigates donors for interfering. Donor concerns about pervasive corruption within the GRSS and the lack of fully functioning systems of accountability within the MOH mean that directing money through government departments is off the agenda for the time being. The current situation leads to resentment on both sides. Donor representatives interviewed for this paper talk of exhausting, almost daily rounds of arguments and shouting matches with MOH officials. The comment of an official from one of the leading donor nations summed up the general mood: "Basically, the government doesn't deserve our cash at the moment."[25]

The decision by South Sudan to turn off its oil supply, forgoing approximately $650 million in lost revenues each month,[26] dealt a further blow to relations, leading some embassies to openly question whether they could continue to consider the GRSS a viable development partner. Aid officials accused GRSS ministers of "playing poker with people's lives"[27] and worried that by stepping in to fill the health care funding gap, they were enabling bad decisionmaking by South Sudan. The awareness that pursuing the alternative course of action would in effect leave ordinary South Sudanese to die left donors feeling angry and exploited by the GRSS.

The oil shutdown derailed plans to get the GRSS to assume more responsibility for the payment of health worker salaries and essential medicines. Until mid-2012, the World Bank funded the procurement and distribution of drugs for South Sudan. An agreement was sought from South Sudan's Ministry of Finance to provide the MOH with the necessary funds to take on the role when

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[24] Author interview with Dr. Richard Laku, director, Division of Research, Monitoring, and Evaluation, South Sudan Ministry of Health, Juba, August 5, 2012.
[25] Author interview, Juba, August 8, 2012.
[26] Alex de Waal, "South Sudan's Doomsday Machine," *New York Times*, January 24, 2012, http://www.nytimes.com/2012/01/25/opinion/south-sudans-doomsday-machine.html.
[27] Background briefing with U.S. official, July 2012.

the World Bank commitment ended. Assurances were made but later withdrawn when the oil revenue stopped flowing and austerity measures were introduced. USAID and the UK Department for International Development (DFID) stepped into the breach and, at the time of publication, were finalizing an emergency funding package to provide essential medicines to South Sudan for the next year. USAID had committed $12 million to the package, but the deal was being held up because of GRSS demands that the money be simply handed over and that the range of drugs on offer be expanded.

Similar disputes have dogged discussions over health worker salaries. Even before the oil shutdown, donors had observed an "apparent pattern of inaction" on the part of the GRSS in turning its commitment to assume responsibility for paying its health workers into reality.[28] Efforts to get the MOH to establish a health worker payroll and pay grade classifications—critical steps in transferring staff from NGOs to government control—repeatedly stalled. An electronic payroll system was finally established in 2011. The complicated and widely divergent pay scales used by NGOs also frustrated efforts to begin the task of harmonizing their salaries with those of government-employed health staff. The economic meltdown that accompanied the oil shutdown scuppered these negotiations.

The International Response to Date

The story of international assistance to South Sudan is one of three partners who should be working together—donor nations, implementing NGOs, and the host government—but who instead are harboring a growing list of mutual grievances and resentments. All three constituencies feel taken for granted and believe they are being unfairly blamed by the others for the failure to set South Sudan on the path toward development. A lot of goodwill has been lost, and a mood of pessimism prevails.

It is unfortunate that the deepening political and humanitarian crisis in South Sudan comes in the middle of a transitional period for many of its donor partners in their relationship with the host country. The main health-related funding mechanisms supported by the United States, the United Kingdom and other European donors, and the World Bank are coming to an end at virtually the same time. For the donors, the prevailing mood of uncertainty has made it virtually impossible to properly plan the next phase of support and try to shift its operational emphasis from relief to development.

Both of the main U.S.-funded health programs expire in the coming months. OFDA, which provides health services in nearly 200 facilities, is due to phase out direct service provision by the end of 2012. The other main USAID-funded program, the Sudan Health Transformation Project, is coming to the end of its second and final phase at the same time. SHTP II, through its implementing partner, Management Sciences for Health, has been delivering high-impact health services in 14 counties

[28] USAID, "Rapid Assessment and Recommendations for Government Payment of Health Worker Salaries in Southern Sudan," August 2010, p. 3.

across all 10 states. Its remit also included some work on health system strengthening, although in reality the main focus has been on health service delivery.

The other main donor mechanisms are the Basic Services Fund (BSF), a pooled fund in which DFID has played the lead role. The BSF has been delivering primary health care, education, clean water, and sanitation, implementing its projects through 37 different NGOs. The BSF was due to expire at the end of 2011, but its remit was extended to the end of 2012. The other main funding mechanism has been the Multi-Donor Trust Fund (MDTF), administered by the World Bank. Within the health sector, the MDTF has supported service delivery but also built capacity at the Ministry of Health, in particular through the development of monitoring and evaluation functions. It, too, expires at the end of December 2012. A fourth funding stream, from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, has already run dry. $176 million was disbursed, more than $80 million of which was directed toward malaria treatment and prevention, before the fund ran out of money and suspended new grant-making in late 2011.[29]

The main funding mechanisms have achieved some significant successes. The health services they have paid for and delivered through their contracting partners have saved countless lives. Anecdotal evidence suggests they have begun to have an impact on reproductive health. One of the NGOs funded by the United States, the International Rescue Committee, has recorded an 80 percent increase in the use of its antenatal services. More than 1,000 women gave birth at their four health care centers in the first half of 2012, compared with less than 400 in the whole of 2011. Immunization coverage has increased, and more children are receiving treatment for malaria.[30] Overall, 96 percent of the facilities supported under the SHTP II are delivering the minimum package of high-impact health interventions, which include basic antenatal services, nutrition, sanitation, and malaria treatment.[31] Monitoring and evaluation systems have been established and harmonized, enabling the MOH to gather its first useful data on basic health outcomes.

At the same time, there have been shortcomings in the way that donor assistance on health has been managed under the current funding arrangements, and these should hold lessons for future engagement. One of the most important is that the sheer scale of South Sudan's health challenge has made it difficult to set priorities and provide anything beyond the most basic level of assistance. The donors have committed to helping South Sudan deliver a Basic Package of Health Services (BPHS), focused on community-based primary health care. The BPHS emphasizes maternal and child health, nutrition, and control of the most common communicable diseases. These are the correct priorities, but other important health issues are excluded, like the treatment of Neglected Tropical Diseases, mental health, and measures to promote preventive health. Some of the U.S. government's health

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[29] The Global Fund, "South Sudan: Regional Grant Portfolio," August 27, 2012, http://portfolio.theglobalfund.org/en/Country/Index/SSD.

[30] Author interview with Wendy Taeuber, health team lead, International Rescue Committee, Juba, August 9, 2012.

[31] Author interview with Dr. John Rumunu, Sudan Health Transformation Project, Juba, August 10, 2012.

priorities in South Sudan do not appear to align with realities on the ground. Both the donors and the GRSS agree on the importance of maternal and child health, yet comparatively little funding goes toward family planning. This is an important omission, given the high fertility rates in South Sudan, the high incidences of teenage pregnancy, and the fact that less than 2 percent of women are believed to use effective methods of contraception.[32] Each year, the United States spends four times more money on the treatment and prevention of HIV/AIDS in South Sudan, which affects an estimated 3 percent of the population, than it does on malaria, a major killer which accounts for a quarter of health diagnoses at medical facilities.[33]

Another difficulty donors have faced in implementing health programs in South Sudan relates to the fact that the unending cycle of humanitarian crisis has frustrated efforts to engage in activities geared toward development. Efforts to build South Sudan's health system and harness host country capacity have been frustrated by the need to divert resources toward more immediate crises. Understandably, donors choose to prioritize activities such as emergency relief and primary health care delivery that save lives now, even though they tend to lead to expensive and inefficient interventions. At the same time, there is a growing sense of frustration that long-term development remains on hold. To cite one example, aid officials are reconsidering ambitious plans to build urban water and sanitation facilities because the GRSS does not have the capacity to run them effectively, and it is too time consuming and expensive to train them. Instead, they are scaling back their Water, Sanitation, and Hygiene (WASH) programs in favor of what one official described as "sinking boreholes; in other words, the least sustainable form of development."[34]

A critical problem that has hampered effective donor engagement on health is that too often the approach has revolved around what implementing NGOs are willing and able to provide, rather than what the South Sudanese themselves actually desire. International NGOs have played a long and important role in South Sudan, delivering emergency assistance and health services during the worst years of the civil war. Because these activities were not effectively coordinated, led, or monitored, they have resulted in a patchwork pattern of service provision, with some areas saturated while others are desperately underserved. The World Bank found in 2010 that per capita spending on health in Upper Nile state was $9.1 per year, while in Lakes state it was less than $1.[35] The current system can best be described as supply driven rather than demand driven. NGOs continue to call the shots, picking the sectors and locations in which they wish to work and creating the perception that they are serving their own interests and employees over the interests of the people of South Sudan. This has generated enormous resentment among South Sudanese, who see many of their most qualified citizens "poached" by NGOs and question what they are receiving in return for losing their best and brightest. The donors are frustrated as well. One senior aid official from a leading donor

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[32] South Sudan Ministry of Health, "Basic Package of Health and Nutrition Services for Southern Sudan," p. 14.
[33] Author discussion with U.S. embassy official, Juba, August 10, 2012.
[34] Ibid.
[35] Author interview with Dr. Mohammed Ali Kalil, senior health specialist, World Bank, conducted by phone from Juba, August 10, 2012.

nation was scathing in her assessment of some of the worst operators, accusing them of using South Sudan as a "playground to try out all kinds of weird and wonderful ideas," and of acting without "consultation, transparency, and accountability."[36]

For their part, the prevailing mood among many NGOs is one of feeling stuck in the middle of disputes between the GRSS and the international donors. They claim with some justification that they are being blamed for the failures of others. The vast majority of international NGO workers are dedicated professionals, having traded comfortable lives in the West to work in one of the world's poorest and most challenging environments, often putting their security and health on the line in the process. The pressures are immense and burnout rates extremely high. As the implementing organizations for the international donors, they bear the brunt of complaints, even hostility, from ordinary citizens when health services do not meet expectations or—as is increasingly the case—when they are withdrawn or consolidated.[37]

Beginning a New Chapter in Health Engagement

While the closure of three major donor funding mechanisms at virtually the same time creates a lot of headaches and raises serious questions over program continuity, it also provides a chance for a fresh start. Successor programs are being designed to encourage better integration between the development partners, more consolidated delivery mechanisms, and smarter use of limited resources. However, the current budget crisis in the GRSS is already forcing donors to scale down their ambitions and push back plans for health system development in favor of a continued near-term focus on health service delivery.

The new approach consolidates health leadership geographically, with each of South Sudan's 10 states being assigned a lead donor. For USAID, the SHTP II program will be replaced in early 2013 by a five-year integrated health program worth approximately $50 million a year,[38] implemented by Jhpiego, an affiliate of Johns Hopkins University. USAID will be responsible for two states, Central and Western Equatoria, in the south of the country. The Basic Services Fund will be replaced by a Health Pooled Fund (HPF), a five-year project led by DFID, with confirmed contributions from Sweden, Australia, and the European Commission. The HPF is trying to secure £123 million worth of commitments (approximately $200 million[39]), and in August, DFID officials said they were already close to reaching that figure.[40] It will take the lead in six states. Finally, the World Bank will roll out the South Sudan Health Rapid Results Project, a $28 million two-year program focused on Jonglei and Upper Nile states. In order to ensure a more even delivery of services, all three projects will

[36] Author discussion in Juba, August 8, 2012.
[37] Off the record discussions with staff at four Juba-based NGOs, August 6–10, 2012.
[38] Sarah Fox and Alex Manu, *Health Care Financing in South Sudan* (Oxford: Oxford Policy Management, January 2012), p. 9, http://www.opml.co.uk/sites/opml/files/HF%20report%20South%20Sudan.pdf.
[39] According to conversion rate of 1 GBP : 1.61 USD, accessed on September 12, 2012.
[40] Author discussion with Simon Williams, head of Basic Services Fund, DFID, Juba, August 8, 2012.

assign responsibility for health service delivery to a single NGO per county, rather than the current system where some counties are served by multiple NGOs while others receive nothing at all. Each of the main donors are also considering alternative delivery mechanisms, one of which includes working more closely with county health departments rather than directly with NGOs in an effort to boost local health system capacity. The World Bank is planning to test a performance-based financing model in some of its counties, whereby the funding given to individual health facilities will be adjusted according to the quality of services they deliver.

The new donor funding models address some of the failings of their predecessors but also raise concerns on a number of levels. First, they will result in wholesale changes at a particularly delicate time in South Sudan. Unless carefully managed, there is a risk that critical services might be interrupted, potentially placing lives in jeopardy. Timelines have already slipped, with all three lead donors extending their current funding mechanisms to accommodate missed deadlines. The new World Bank project was supposed to begin in April 2012 but was still not ready by the Fall, a delay that was blamed on the failure of the GRSS to sign the necessary documents.[41]

Funding gaps are another potential problem. Although all of the donors insist that the new system will maintain current levels of funding on health, others are dubious. The amount of money earmarked by the World Bank for Jonglei and Upper Nile, two of the largest, least secure, and most health deficient states in South Sudan, has raised concerns. One NGO estimates that the needs of the two populations require health spending of between $15 and $20 per person, per year, as opposed to the $6 per person envisaged by the World Bank.[42] Other organizations have warned that the one NGO per county model of health delivery outlined under the new donor mechanisms will inevitably lead to service cutbacks.

The overriding problem with the new health projects, however, is that they are already backtracking on plans to shift the emphasis from relief to development. While this is understandable given the palpable lack of progress on the ground and the current budget uncertainty with the GRSS, they appear to extend an expensive, unsustainable approach to health engagement that is destined to further strain relations with the host government. For the United States, a "more of the same" approach is likely to raise concerns in Congress as costs mount without signs of improvement on the ground. While the new funding mechanisms acknowledge the importance of developing host country capacity, they will continue to rely heavily on international NGOs to implement health projects. Again, this is understandable given the reality that competent local organizations do not exist and the GRSS at all levels is not able to use funding in a transparent, accountable manner. However, donors face a conundrum in that the host government is unlikely to become more responsible until it is given more responsibility. For the time being, the entirely understandable calculation donors have made is that the fiduciary risk is simply too high to justify placing funds

[41] Author discussion with Dr. Mohammed Ali Kalil, World Bank, Juba, August 10, 2012.
[42] Author interview with Wendy Taeuber, International Rescue Committee, Juba, August 9, 2012.

directly in the hands of the GRSS. The likely consequence of this decision is that development in South Sudan will continue to stall.

Where Do We Go from Here? Recommendations

- *Time for some tough love.* South Sudan achieved independence in July 2011 on a wave of optimism and international goodwill. The United States was a loyal supporter of Juba when most of its current government was still fighting in the bush. It has provided humanitarian assistance to its people, and its diplomatic investments helped bring an end to the civil war, placing South Sudan on a path to self-government and ultimately independence. It has provided money, technical assistance, and helped stand up government institutions. It has funded and delivered health services to citizens who would have died without its intervention. It has been, and remains, committed to helping South Sudan become a peaceful, prosperous nation. But its investments risk being squandered because of the self-destructive actions taken by the GRSS since independence.

  The decision by the GRSS to turn off its oil supply was a turning point. Arguably there may have been good tactical reasons for the move; South Sudan was in the middle of a tough negotiation process with an intransigent government in Sudan that was demanding extortionate fees to use its oil pipeline. But the government's decision also demonstrated contempt for the welfare of its citizens and exposed a cynical assumption at the heart of its calculations—that the international community would step in to fill the funding gap and continue to play the role of public service provider to the people of South Sudan. This attitude must not go unchallenged.

  Even before the oil shutdown, U.S. officials had complained that Juba was not in "listening mode" and described the attitude of government officials as one of "aggressive dependency," in which assistance was demanded with no strings attached.[43] U.S. officials are fond of saying that the United States has limited influence over Juba. As the largest bilateral donor to South Sudan and its most steadfast friend, this simply cannot be the case. Rather, there remains a residual reluctance to strongly criticize Juba, which can perhaps be attributed to historic ties and an appreciation for the suffering it endured at the hands of the regime in Khartoum.

  Recently, there have been signs of a shift toward a more assertive response. In a letter whose contents were widely reported in the local press, The U.S. ambassador to South Sudan, Susan Page, warned that U.S. funding was "not a gift" and said that failure to adhere to democratic standards would lead to the "immediate loss" of foreign assistance.[44] This message is the right one to convey, provided it is backed up with actions when necessary. Public diplomacy, if used sparingly, can be an effective tool in holding the GRSS accountable to its people,

[43] Background conversations with U.S. State Department officials.
[44] "Undemocratic rule will lose S. Sudan US support, envoy says," *Sudan Tribune*.

helping Southern Sudanese citizens make the link between government performance and effective service delivery.

The United States wants South Sudan to succeed and does not wish to take steps that might weaken it further. But in the interests of long-term stability, it must start attaching conditions to its nonemergency assistance, exerting maximum pressure on Juba to set a more proactive agenda for development that goes beyond rhetorical demands for ownership.

- *Establish clear benchmarks for progress.* The new health funding models being introduced by the main donor nations provide an opportunity to define a course that will ultimately start to shift engagement from primary health service delivery to health system development. Already, timetables have been derailed because of the austerity measures introduced in the wake of the oil shutdown. The reality is that emergency relief will remain an important component of health programing for some time to come. At the same time, it is important to prevent the current crisis from allowing policy to drift. The United States must continue to push the development agenda and should reset its health relationship with South Sudan around a new partnership agreement with the GRSS. This agreement should spell out mutual expectations and contain clear performance benchmarks, including penalties for missing targets. It should lay out a path toward the future transfer of responsibility for health worker salaries and drugs payments to the GRSS, tied to specific budget commitments, even though such a handover is not possible in the current economic environment. If the GRSS wishes to aspire to genuine ownership of its health system, assuming financial responsibility for its key components will be critical in the long term.

  Donor coordination will continue to be important in helping the international community hold Juba's feet to the fire on its conduct. While donors may wish to avoid the appearance of ganging up on Juba, it is far more important to ensure that they speak with one voice so that they convey clear expectations of the GRSS. The health sector working group, chaired by Canada, provides a useful forum for dialogue between the main donors and the MOH, and its work should be supported. Its discussions should include more input from the NGO community, offering opportunities for the three major health stakeholders to clear the air and try to resolve outstanding grievances.

- *Focus more on state- and county-level health system development.* Donors will continue to engage the central government in Juba but are scaling back their expectations of what can be achieved with a partner whose political will is open to question. Corruption and poor governance is no more or less a challenge below the national tier of government, but there are a broader range of individuals and institutions to engage with at the state and local level. Local officials are more closely tied to their communities, which can make them more responsive to their needs and demands. Development professionals relate stories of witnessing at the village or county level individual acts of selfless public service in the face of overwhelming odds. As one official puts it: "It's at the local level where you really see people

committed to serving their new country, often with virtually no resources. You don't tend to see that same level of dedication in Juba."[45]

The GRSS is publically committed to a policy of decentralization as a means for getting public services out to its citizens, but its enthusiasm is open to question. Decentralization means ceding control of funding, something government officials in Juba are reluctant to do. A proposed blueprint has been established for the GRSS to ultimately take responsibility for transferring donor funds to the state level through a so-called Local Services Support Aid Instrument. The donors are currently unwilling to give the GRSS this responsibility because of fiduciary concerns, but they should work toward this goal as a long-term strategy for development.

Conclusion

In September 2012, the governments of Sudan and South Sudan reached a cooperation agreement to resolve a set of longstanding security and economic disputes. The deal opens the way for the resumption of oil production in South Sudan, raising hopes that the new country can at last embark on the path toward recovery and development. With oil revenues due to begin flowing again in early 2013, the GRSS has an opportunity to show that it is committed to improving the lives of its people, who have suffered years of violence, neglect, and disease. The best way it can do this is to take on responsibility for providing critical health services and training and sustaining a cadre of professional health workers.

The main task of the United States, as a friend of South Sudan and its citizens, is to hold the GRSS to its commitments. The time for excuses is over. South Sudan will continue to require support, technical assistance, and money. But most of all, it needs a partner that will apply pressure on the GRSS to start assuming responsibility for its citizens. This means advising and supervising South Sudan in the development and implementation of a long-term strategy to build a health system that will sustain itself without outside support. The ultimate goal is that South Sudan will take on sole ownership of its affairs and begin performing the core functions of an independent nation state; namely, proving an environment that allows its citizens to live in peace, prosperity, and good health. Failure to achieve this goal will have disastrous costs, in human and financial terms. South Sudan will continue to lurch from crisis to crisis, and the United States will continue to sink money it can ill afford into short-term, emergency-driven programs that may save lives but will not result in long-term improvements to public health.

[45] Author interview with USAID official at U.S. embassy, Juba, August 10, 2012.

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