DEVELOPMENT ASSISTANCE FOR HEALTH (DAH) IN POST CONFLICT REGIONS: IMPACT ON LOCAL HEALTH PRIORITIES AND EQUITY IN SOUTH SUDAN.

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South Sudan

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Development Assistance for Health (DAH) in post conflict regions: Impact on local health priorities and equity in South Sudan.

A thesis submitted in partial fulfilment of the requirement for the degree of Masters of Public Health

By

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Abbreviations and Acronyms

BPHS	Basic Package of Health Services
BSF	Basic Services Fund
BSWG	Budget Sector Working Group
CHDs	County Health Departments
CHF	Common Humanitarian Fund
CHW	Community Health Worker
CPA	Comprehensive Peace Agreement
DAC	Development Assistance Committee
DAH	Development Assistance for Health
EmONC	Emergency Obstetric Neonatal Care
FMIS	Financial Management Information System
GAVI	Global Alliance for Vaccines and Immunization
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHE	Government Health Expenditure
GoSS	Government of South Sudan
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSDP	Health Sector Development Plan
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDCF	Inter-Donor Coordination Forum
IDP	Internally Displaced Person
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
JAM	Joint Assessment Mission
JDO	Joint Donor Office
MDGs	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NNGO	National Non-Governmental Organisation
NSCSE	New Sudan Centre for Statistics and Evaluation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OLS	Operation Lifeline Sudan
PAHO	Pan American Health Organization
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care

PHCCs	Primary Health Care Centers
PHCUs	Primary Health Care Units
PMI	President's Malaria Initiative
PPP	Public-Private Partnership
RSS	Republic of South Sudan
SBS	Sector Budget Support
SHTP	Sudan Health Transformation Project
SMOH	State Ministry of Health
SSDP	South Sudan Development Plan
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

Glossary of terms

The definitions below are adopted from the publication of the Institute for Health Matrix and Evaluation (IHME 2009), and are used throughout in this research paper.

Developing Countries: These are low-income and middle-income countries, as classified by the World Bank's country groupings.

Development Assistance: These are financial and in-kind contributions from external sources for promoting economic, social, and political development in developing countries.

Development Assistance for Health: These are financial and in-kind contributions made by channels of development assistance to improve health in developing countries. It includes all disease-specific contributions as well as general health sector support, and excludes support for related sectors.

***Channels of Development Assistance*:** they are institutions whose primary purpose is to provide development assistance. They include bilateral donor agencies, multilateral agencies, public-private partnerships, private foundations, and non-governmental organizations.

Implementing Institutions: These are international and domestic actors implementing health programs for improving health in developing countries.

Grant and Loan Commitments: Are promises of future payments of a specified amount made by donors to recipients.

Annual Disbursements: On grants and loans are the actual payments made against a prior commitment.

***Development Assistance Loans*:** are **concessionary** in that they are either interest-free or charge an interest rate that is below the prevailing market rate.

Gross Disbursements: These are the actual outflow of resources in a given year.

Net Disbursements: Refer to the gross amount minus repayments on previous loans.

Financial Contributions: are gross disbursements on health grants and concessionary loans.

In-kind Contributions: are costs incurred from delivering health services, drug donations, providing technical assistance, and administering grants and loans.

Post-Conflict Region: A country or region is considered to be **post-conflict** when active conflict ceases and there is a political transformation to a recognized post-conflict government (World Bank 2007).

Official Development Assistance: The OECD defines Official Development Assistance (**ODA)** as "flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional in character with a grant element of at least 25 percent (using a fixed 10 percent rate of discount (IMF 2003)

Development Aid: This is defined as development funds to the health sector, as reported by the OECD-DAC ODA Creditor Reporting System (CRS) database, excluding humanitarian funds which are also reported by the CRS but not by sector (OECD-DAC 2006).

Humanitarian aid: These are funds reported by the UN Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (FTS) (OCHA 2007).

Dedication

I dedicate this Thesis to all heroes and heroines of South Sudan who shaded their blood in the long war of liberation; in the bid to usher peace and liberty in the new Republic of South Sudan.

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I thank my academic mentors (Thesis advisor and back stopper) for dedicating their time to guide me through the writing of this Thesis. To the Royal Government of the Netherlands, to all KIT administrators and academic team, friends and relatives, my honest indebtedness.

Abstract

Introduction: Since the CPA, The Republic of South Sudan (RSS) has witnessed a flow of DAH from donors. However, approximately 8 years in, the health sector still suffers, because of the fragmentation of donor support; with different interests in funding of specific activities and projects. There are cross-country inequities intensified by the disproportionate allocation of aid funds in the different regions. Despite significant growth in DAH in recent years, fundamental challenges still remain in the newly independent country's ability to raise the required finances and ensuring that the funds are spent effectively in accordance to her planned development strategies and objectives.

Methods: Literature review. Data available from the year 2005 to 2012 was used for the analysis of flow of funds in health (DAH) to South Sudan.

Findings: Trend of DAH flow to the Republic of South Sudan has been unpredictable. There is multiplicity and proliferation of many development partners with different interests, working in geographical areas of their choice and implementing their own health interventions. The weak institutional capacity in RSS has hindered alignment and harmonization of DAH with local priorities. The fragmentation of aid has further contributed to poor resource allocation and widened geographical disparities (Inequity).

RSS is largely dependent on oil revenues to fund her entire budget. Very little is achieved from other forms of domestic resources like taxation, because of challenges of capacity and poor legal frameworks.

RSS government budget expenditure on health is far away below 4.9%, as compared to the 15% target set by the African Union heads of state in 2001 in Abuja.

Conclusion: Alignment of DAH to RSS priorities and achieving equity through equitable resource allocation has been very challenging for the country, due to weak institutional capacity.

Recommendation: Donors need to align and harmonize aid with RSS priorities. RSS government needs to establish sound micro-economic policies for domestic revenue mobilization; and find alternative community financing arrangement for health (Community Health Insurance) to empower the community and reduce their catastrophic expenditures. RSS can further look for the best policies to integrate civil society and private sector in the aid coordination process.

Key words: South Sudan Government, Development Assistance, Foreign Aid, Health Financing, Health system, Health equity, Health equality, Post-Conflict, Paris declaration, World health organization, Fragile states.

Word Count: 10,546.

Introduction

Stakeholders at all levels; local, national and international require timely and reliable financial information to make informed decisions on how efficiently to use scarce resources to meet pressing health needs. In the authors six years of work experience as a Grants Accountant for health projects in RSS, with Non-Governmental Organizations (NGOs), he wanted to know the dynamics of Aid flow to developing countries (for example: Official Development Assistance (ODA), and Development Assistance for Health (DAH) by multiplicity of donors), as well as the mechanism of managing such foreign Aid by the recipient countries.

That experience prompted the author to explore the dynamics of DAH to post conflict regions, with emphasis on the Republic of South Sudan; especially in the implementation of "Basic Package for health Services" (BPHS). Further, the author wanted to explore how they impact local health priorities and equity (Geographical Equity). The fundamental issues here are: whether donors are harmonising or aligning aid according to local needs, or whether resources (funds) are being equitably distributed to all regions of the country to ensure that health goals/targets of universal health coverage and access are achieved[1].

Between 2001 to 2010, total global ODA significantly increased, to approximately US$148.4 billion; while the share of ODA for health fluctuated. However, by 2010 ODA for health increased to more than 12% of the total ODA. Importantly, global DAH grew to US$28.2billion in 2012, with support from multilateral organizations, Public-Private Partners (PPPs), world Bank(WB) and Foundations. Sub-Sahara Africa region received the largest share US$ 8.1 billion or 28.7% of the total DAH (IHME 2012).

ODA represents an important source of financing in South Sudan. According to the RSS Ministry of Finance Economic Planning (MoFEP) and National Bureau of Statistics (SSNBS), between 2008 and 2011, US$3.8 billion worth of commitments were made to RSS. Between 2008 and 2010 the health sector received approximately 23.0% of the total proportion of ODA as DAH, with the funds being channeled through multilateral institutions or pooled (Okwaroh. K, 2012).

Despite the significant flow of DAH from proliferation of donors, the health sector in RSS still suffers; showing the worst health indicators in the world (Maternal mortality ratio is 2054/100,000 live births and Infant mortality rate is 102/1,000 live births and the under-five mortality rate is 135/1,000 live births) (SSHHS

[1] "I regard universal health coverage as the single most powerful concept that public health has to offer. It is inclusive. It unifies services and delivers them in a comprehensive and integrated way, based on primary health care." Dr Margaret Chan, WHO Director-General, 2012.

2006). International guiding principles for donor aid like the "2005 Paris Declaration" and country specific regulatory documents such as "South Sudan expenditure priorities 2008-2011 and the Aid strategy", exist; yet the main problem of fragmentation of donor support with different interests in funding of specific activities and projects making donor coordination of activities challenging, persist. Fragmentation has further resulted in cross-country inequities as intensified by the disproportionate allocation of aid flow to the different regions or general imbalances of aid flows by donors to the country.

The analysis and discussion of this Thesis will be structured around Walt and Gilson (1994) ***Policy Triangle framework*** for health policy analysis. The Framework will examine whether RSS is aligning donor funds according to national priorities and if resources are being equitable distributed to address the issue of inequity. This frame work may not offer the best analysis in trends of Aid flow but it tries to bring out the policy issues surrounding Aid flow. Based on the findings, recommendations will be made to the government of RSS and all other key stake holders.

1 Chapter 1: The context of South Sudan

This chapter gives an information synopsis on RSS. A glance at the general background information on its, historical and political context; Demographic and Socio-Economic context; Geography and topography; health status and disease burden; and the general health system.

1.1 Geography

Location:

RSS is landlocked geographically located in the East-Central African region. It is bordered by Sudan to the North , Ethiopia to the East, Kenya and Uganda to the South, the Democratic republic of Congo to the South West, the Central African Republic to the West.

Climate:

It has the equatorial or tropical climate with two seasons; April-November (Wet season) and December- March (Dry season). The average annual temperatures reach a high of 34.5°C (94.1°F) and a low of 21.6°C (70.9°F). The average yearly total for rainfall is 953.7 mm. Most of that falls in the period between the months of April to October.

Terrain:

The country has widely contrasting terrain with vast low lying plains traversed by many rivers and streams, Mountainous to the north and to the west. Significantly large areas of the country are swampy marshland mostly "The Sudd" (floating vegetation) fed by the waters of the White Nile that dominates the center of the country; that frequently flood during the long rainy season between April and November of each year. The topographic and climatic conditions form a rich ecosystem for a number of human parasites and vectors that cause serious diseases.

1.1.1 Administrative divisions

RSS runs a federal government system. With three levels of government; the Federal Government with a government seat in Juba the Capital City of the country; the State Government with seats of government in the respective state capitals of the ten (10) states; and the Local Government with seats of government in the respective county headquarters of the seventy nine (79) counties. The county administration is further decentralized to smaller administrative authorities locally known as Payams, which are further divided into units known as Bomas to represent traditional village arrangements. In all, there are 10 States, 79 Counties, 514 Payams and 2,159 Bomas.

Due to insecurity and the vast geographical extent of the country, effective health service coverage has remained low at under 25 % (HHHS 2008).

1.2 Historical and Political Context

1.2.1 From occupation to independence

Until recently, RSS was part of the Republic of Sudan, which was "then" a British colony. The long-lasting conflict that lead to the creation of RSS began in the early 1820s, as a result of the North–South division of Sudan. The division was due to the imposition of Turco–Egyptian rule in Sudan (then known as Equatoria) that vastly increased the scale of official slave-raiding from Muslim areas against non-Muslims. Many revolts were waged and the Addis Ababa agreement was reached in 1972.

Between 1983 and 2005 the Sudan People Liberation Movement (SPLM) led by the Late Dr, John Garang de Mabior fought another war against the Sudan government because of the abrogation of the 1972 Addis Ababa agreement. During this period an estimated 2.5 million people died while about 4 million were displaced. A Comprehensive Peace agreement (CPA) was signed between the government of Sudan and the SPLM in January 2005, ushering an interim period of six years for the South to have an autonomous government under the Government of South Sudan (GoSS) until January 2011. After the end of the interim period a Southern Sudan Referendum on Self-determination was conducted and over 98 % voted in favour of secession.

On July 9th, 2011 RSS was created ending more than 190 years of foreign occupation and beginning of a transition period for a people desperately struggling for good governance and nation building.

1.2.2 Current political structure

The federal government has three branches:

The Executive-led by the president of the republic. The president is the head of government and Commander-in-Chief of the Sudan Peoples' Liberation Army (SPLA). The president exercises powers in accordance to the Transitional constitution 2011. *The Legislature*-There is unicameral National Legislative Assembly (SSLA) that approves plans, programs and policies of the National Government; and *The Judiciary*-There is an independent judiciary with the highest court being the Supreme Court. In addition there are many independent commissions and chambers that oversees specific national programs e.g. South Sudan HIV/AIDS commission exist that are appointed either by parliament or by presidential decrees.

A number of Donor missions, semi-formal and informal co-ordination mechanisms exist between donors and government of RSS, even pre CPA period. For instance the Budget Sector working groups (BSWGs), Inte-Ministrial Appraisal committee (IMAC), GoSS Donor Forum, Inter-Donor Co-ordination Forum (IDCF), G6 (6 largest donors & orgnaisations), Joint Donor office (JDO). These coordination forums are supposed to meet regularly or at quarterly or annual basis; except for the weak capacity of some of the forums, coordination has become challenging.

According to the Transitional Constitution of South Sudan (2011) and the Local Government Act (2009), the country operated an adhoc decentralized devolution system in the health sector with 4 tiers, but it is tending to fully decentralization policy soon.

1.3 Demographic and Socio-Economic Context

1.3.1 Demography

The population is estimated at 8,260,490 million with a density of 15 people per square kilometer. More than 90% of the population lives in rural areas. The average annual population growth rate is 2.2%. The population is projected to increase to 12 million by 2015, due to both the annual growth rate and the return of refugees, Internal Displaced persons (IDP's) and South Sudanese from the diaspora (SSCSE 2008).

1.3.2 Economy

RSS has abundant natural resources that remain untapped. Income per capita is extremely low, about half of the population (50.6%) living on less than 1 US$ per day (SSCSE 2008). In addition to high levels of poverty, South Sudan has a high disease burden and low levels of education, thus ranking as one of the poorest countries in the world. The economy depends heavily on imports of goods, services and capital from neighboring countries. The government meets nearly 98% of its budget by revenue from oil extraction, the only resource industry with significant presence in the country.

The vast majority of the population is engaged in rural subsistence farming and cattle herding. Living conditions are associated with poor access to portable drinking water (less than 50% accessibility), poor access to proper sanitation (less than 7% accessibility) and high illiteracy rates among the adult population (88% among women and 63% among men) (HHHS 2010). The country does not have large external debts and structural trade deficits but it has received more than US$3.8 billion in foreign Aid, for health since 2005, but the per capita total expenditure on health is US$141 (SSNBS 2012). The main donors are from the UK, USA, Norway and the Netherlands.

Gross Domestic Product (GDP) per capita of South Sudan in 2010 was equivalent to US$1,505, while the Gross National Income (GNI) per capita was much lower, at US$984 in 2010. In 2011, the country indicated a GDP per capita of US$1,858, which is much higher than its East African neighbors (World Bank 2013).

The budget for 2012-2013 was SSP (South Sudanese Pounds) 9bn (around US$3bn), supplemented by US$1bn of development assistance, and another US$ 300 million of humanitarian assistance. The economy has been plagued with

high inflation in the 12 months following independence, reaching 80% during the year of independence. The price increases by end of 2012 became moderate at 17% (World Bank 2013).

1.3.3 Culture and Religion

According to the 2008 census, 300 Ethnic groups that are predominately nomadic pastoralist and sedentary farmers are found in the country. These tribes vary in cultural beliefs and traditional practices. The official language is English and the national language is Juba Arabic. Traditional cultural origin and dialects are upheld. The religious make up of the country is as follows: approximately 60.5% Christians, 32.9% traditional African religion and 6.2% Muslim (SSCSE 2008).

1.4 Health

1.4.1 Burden of disease

Poverty and socio-economic marginalization caused by many decades of conflict, have negatively impacted the health of the population and the health system in RSS, particularly maternal and child mortality being highest in the world.

1.4.1.1 Reproductive Health and child health

According to the Antenatal care surveillance report; 2006, Maternal Mortality Rates (MMR) in RSS is the highest in the World; estimated at 2054/100,000 live births. Although about 46.7% of pregnant women attend at least one Antenatal Care (ANC) visit, only 14.7% of deliveries are attended by skilled Health workers (HW's). Infant Mortality Rate (IMR) and Under-five Mortality Rate (UMR) are very high at 102 per 1000 live births and 135 per 1000 live births, respectively.

1.4.1.2 Communicable Diseases

Malaria, TB and HIV/AIDS form the biggest disease burden in RSS. According to the 2009 South Sudan Malaria Indicator Survey (SSMIS), Malaria accounts for 24.7% of all diagnoses reported by health facilities. The National Tuberculosis Program reports that the annual incidence of all forms of TB is estimated at 140 per 100,000 population (79/100,000 are smear positive cases). HIV/AIDS prevalence is estimated at 3%, with the epidemic considered to be generalized; although some areas are described as hot spots (SSAC 2012).

1.4.1.3 Non-communicable Diseases

Scanty evidence indicates that the burden of non-communicable diseases (NCDs) is on the rise, especially injuries related to road traffic accidents, cardiovascular diseases (hypertension, stroke) and diabetes. NCDs control has never been prioritized in the MoH budget since 2005.

1.4.2 The health system

The MoH operates a decentralized structure system, that follows four tiers; (i) Primary Health Care Units (PHCUs) that serve close to 15,000 people; (ii)

Primary Health Care Centres (PHCCs) that serve about 50,000 people; (iii) County Hospitals (CH) that serve close to 300,000 people; and (iV) State Hospitals (SH) / Teaching Hospitals (THs) with a catchment of about 500,000 people.

The UN agencies and NGO's play key roles in health service but their interventions are typically focused on primary health care services and emergency humanitarian health assistance. Health services are provided free, with no Out of Pocket charges (OOP) by the government of the RSS.

Traditional medicine is practiced by many, out of conviction. Private for-profit sector is minimal and does not play a big role in health service delivery. The National Health Insurance Services (NHIS) is only for a few government civil servants.

2 Chapter 2: Study outline

The chapter aims to explore the problem under study, the justification, the objectives of the study, the methodology, and the conceptual framework.

2.1 Problem Statement, Justification, Objectives and study Methodology

2.1.1 Problem Statement

The extent of the problems with the health system in RSS was not realised until after the extensive war; when the new government embarked on a series of measures to address the reconstruction of the health system. Despite the establishment of government-led aid coordination mechanisms, the new government continues to have weak deliverance strategies, as a result of limited resources, weak institutional capacity in planning and low financial base. The international donors are willing to provide aid to the health sector. However it is unclear (there is a dilemma) whether this aid is being aligned to national priorities or whether the resources are equitable distributed across the.

The donor multiplicity has led to the division (fragmentation) of DAH into numerous different projects or programs, that are delivered by a wide variety of donors. As a result RSS has witnessed a substantial proliferation of active donors in the health sector, with different interests in funding specific programs and projects in the country.

The resultant of this fragmentation is duplication of many health programs and projects across the country, making it difficult for the government of South Sudan to track all aid programs. Many regions of the country remained underserved (inequity) due to lack of DAH not being aligned or harmonised with national priorities.

2.1.2 Study Justification

In RSS, global principles of Aid effectiveness will not be achieved or implementing due to the weak alignment between Development partners (DPs) and local priorities and the poor practical coordination mechanism among DPs.

The aid effectiveness agenda as defined in the 2005 Paris Declaration and reviewed by the recent Accra Agenda for Action and Kishasha Statement on Fragile States, aims to enhance ownership, donor alignment to national governments, donor harmonization, mutual accountability and managing for results (Wood et al 2008). Furthermore the Good Humanitarian Donorship Initiative and the OECD-DAC's "Principles for Engagement in Fragile States" have made similar pledges around aid effectiveness; not matching local priorities and not taking equity issues with donor aid for health in post conflict regions like South Sudan can be an indicator of "Aid ineffectiveness" (OECD 2008).

The proposed framework for health goals in the post 2015 agenda needs to be achieved. Provision of all people with access to affordable, comprehensive, and high quality services that address basic health requirements and national priorities is a means to achieve better health results. Therefore it means ensuring universal health coverage and access to all.

2.1.3 Study Objectives

2.1.3.1 General Objectives:
The general objective of the Thesis is to examine the volume, nature and purpose of external aid and its alignment to local priorities, and to make recommendations to the Government of RSS as well as other stakeholders in order to improving equitable distribution of available financial resources.

2.1.3.2 Specific Objectives:

1. To identify the various key players both private and public, and their role in directing flow of Development Assistance for Health to the government of the Republic of South Sudan;
2. To describe the nature and purpose of aid provided and to quantify the distribution of development assistance for health;
3. To examine whether fund allocation by donors is in line with the national health priorities;
4. To identify the relationship between Development Assistance for Health and South Sudan Government Health expenditure; and
5. To make evidence-based recommendations to donors and the Government of the Republic of South Sudan on improving the alignment of aid with national priorities and a more equitable distribution of financial resources in the health sector.

2.2 Study Methodology

The study methodology for this Thesis consists of a literature review. Search engines used to obtain information include Google scholar, PubMed, and Scopus. The KIT Library was also visited. Grey literature was obtained from websites including that of the RSS MoH, the WHO and INGOs, Community Based Organizations (CBOs) for health working in South Sudan.

2.2.1 Literature review

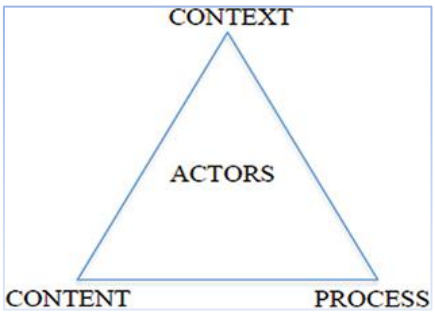
The Boolean search, key words used (singly or in combination) include: Republic of South Sudan, Development Assistance, Foreign Aid, Health Financing, Health system, Health equity, health equality, Post-Conflict, Paris declaration, Kinshasha statement, Accra Agenda, World health organization, Donors, Budgets, Ministry of Health, Fragile states.

2.3 Conceptual Framework

The framework is based on Walts and Gilson (1994) ***"Policy Triangle framework"***, for health policy analysis. This framework is only adopted to

conceptualize the aspects of DAH alignment to national priorities and equitable distribution of resources.

Figure 1: Walt's Policy Analysis Triangle



Source: Walt, G. (1994) Health Policy: An Introduction to Process and Power.

The framework tries to explain the influence of three main factors (Context, Content and Process) on the actors within the wider policy environment.

Actors: include individuals, organizations, and the Government. They have interests, power, position and commitment to influence policies. In this case the actors in the flow of DAH are the Donors (Multilaterl, Bilateral & private), Government of the Republic of South Sudan, MoH and MoFEP, and the implementing agents (NGO's, both national and interantional) etc.

Context: The context here is the background within which interventions are mediated. Therefore, it shapes and is shaped by external stimuli, like structural and cultural factors.

Content: Refers to the object of policy and policy analysis, and may be divided into technical and institutional policies. These may include, in this case, the Paris Declaration 2005, the South Sudan Health sector development plans (HSDP), South Sudan Aid Strategy 2008 and South Sudan Priority expenditures 2008-2011. These are guiding policy documents.

Process: Refers to the means of achieving implementation of a policy; i.e. policy formulation and evaluation.

3 Chapter 3: Results

This chapter examines the existing global and national policies in managing DAH. it outlines the trends in flow of ODA and DAH (nature & volume) to developing countries, conflict regions and the Republic of South Sudan.

3.1 Content: policies and priorities related to health care financing

3.1.1 International donor policies and priorities

The international policies and priorities related to flow of ODA and DAH are enshrined in the following global initiatives in which both donors and recipient countries agreed on, especially among the OECD-DAC member countries.

(i) The 2005 Paris Declaration on aid effectiveness and Accra Agenda for Action (AAA): both aimed at harmonising international aid efforts to focus on country's own development strategies, so as to achieve international health targets, including the Millennium Development Goals (MDGs). They are based on the 2003 Rome declaration on harmonisation and alignment;

(ii) Good Humanitarian Donorship initiative (GHD): meant for donor governments and stresses on addressing a perceived lack of donor adherence to established principles, particularly needs-based resource allocation, and recognizes the need to respect the modus operandi of partner agencies;

(iii) Fragile states Principles (FSPs): it looks at fund predictability, prioritizing prevention and capacity building. However its core objectives are state and peace building; and

(iv) The global health initiatives like Global fund and GAVI focuses on specific diseases programs and run vertical programs alongside governments.

3.1.2 National health policies and priorities

During the interim period, South Sudan developed many policy documents to guide as regulatory frameworks between its government and development partners. These policies clearly stipulate the priority expenditures and the guiding principles that enhance aid effectiveness.

In a post-conflict environment like the one in South Sudan, everything in the health sector is a priority, however, there are limited resources and capacity to effect these priorities. As part of determination to focus on the major challenges in the health sector, a government health policy was formulated in 2006 to focus on 18 health priorities. Ten (10) of the Eighteen (18) health

priorities are grouped below and are outlined as top priority for resource allocation (Health Policy-GoSS, 2006-2007).

Health services strengthening: Reduce inequalities in access to health care, community participation, development and implementation of minimum package of health care, development and implementation of essential hospital services package, improved delivery of maternal and child health interventions, health facility infrastructure development.

Health systems development: Institutional & Human Resource Development, Health financing & Health Policy Development, Monitoring and Evaluation, Coordination, Communication and Networking.

The Ministry of Finance and Economic Planning (MoF&EP) in 2007 came up with the expenditure priorities and funding needs for 2008-2011, where 6 priority areas for the country were identified, health inclusive with the main objective of providing **primary health care.** In order to achieve this objective, targets were set and each health intervention and activity was costed (MoF&EP 2008). The main activities required to deliver the targets by 2011 include:

- Increase basic health service coverage to 50% of the population.
- Reduce infant and maternal mortality rates by 25%.
- Increase routine vaccination coverage from about 30% of the population to 90%.
- Increase the awareness of HIV/AIDS from less than 10% of the population in 2007 to 90% of the population.
- Provide basic health services to approximately 6 million people.
- Provide routine immunization to half a million children under the age of one per year.
- Reach almost 9 million people through vaccination campaigns.
- Distribute over 2.5 million bed nets.
- Increase the stock of functioning health facilities by 10% from the current baseline of 1063, by constructing/rehabilitating and equipping 9 hospitals, 40 primary health care (PHC) centres, and 60 PHC units.
- Increase the number of qualified health workers by 4,000, through a combination of in-service and formal training.
- Sensitise 25% of all primary teachers and Alternative Education System (AES) instructors in HIV/Aids each year.
- Carry out 6 mass media campaigns and HIV/Aids awareness outreach programmes per year.

Table 1. Estimated cost of health Priorities (US$'000) 2008-2011

	2008	2009	2010	2011	Total
Basic health package	93.5	102.5	111.0	119.1	**426.1**
Routine immunisation	25.0	18.5	18.4	17.1	**79.1**
Vaccination campaigns	10.9	10.4	9.5	8.4	**39.2**
Mosquito bednet distribution	6.9	7.1	7.3	7.5	**28.7**
Construction & rehabilitation of health facilities	23.3	37.2	56.3	61.7	**178.5**
Training	12.0	13.5	15.5	17.4	**58.4**
Capacity Building	1.6	1.5	1.2	1.1	**5.4**
HIV/Aids awareness	2.1	2.6	2.4	2.2	**9.3**
Total	**175.3**	**193.4**	**221.6**	**234.4**	**824.6**

Source: MoF&EP 2008.

The health priorities in the Health Sector Development Plan (HSDP)

The Basic Package for Health Services (BPHS) guides service delivery, but donors have agreed to focus on an "Essential" or "minimum" package. Therefore since the donors have different emphasis on programs in terms of technical output, it is imperative the guiding document for the operational plan is the HSDP 2012-2016. The HSDP stipulates that, all activities must be fully aligned with the priorities set in the document and the HSDP should also be aligned to the South Sudan Development Plan (SSDP) which is the strategic document of the government (Fox. S and Manu.A 2012). Therefore, all donor activities/programs should be aligned to the priorities set forth in the objectives of the HSDP that span for a period of 5 years, which include:

a) *Increasing the utilization and quality of health services*. Meaning development partners in health will contribute to improved access, use and quality of primary health care (PHC) and Emergency Obstetric Neonatal care (EmONC).
b) *Increasing health promotion and protection*. Health partners will contribute to increased equity and effectiveness through the community and health education
c) *Strengthening institutional functioning, governance and health system effectiveness, efficiency and equity*. Health systems strengthening in all levels of the central MoH, SMoH and CHDs interms of governance and leadership. Additionally to include management system, capacity development and monitoring and Evaluation (M&E).

3.2 Context

3.2.1 International

3.2.1.1 Trends in overall Aid to Low/Middle Income countries

According to IHME 2012, between the period 1990 and 2001, overall ODA decrease from US$99 billion to US$92.2 billion respectively. In 2010, total ODA increased to US$148.4 billion; a 61% expansion between 2001 and 2010. While in 2011 it decreased by 1.2%.

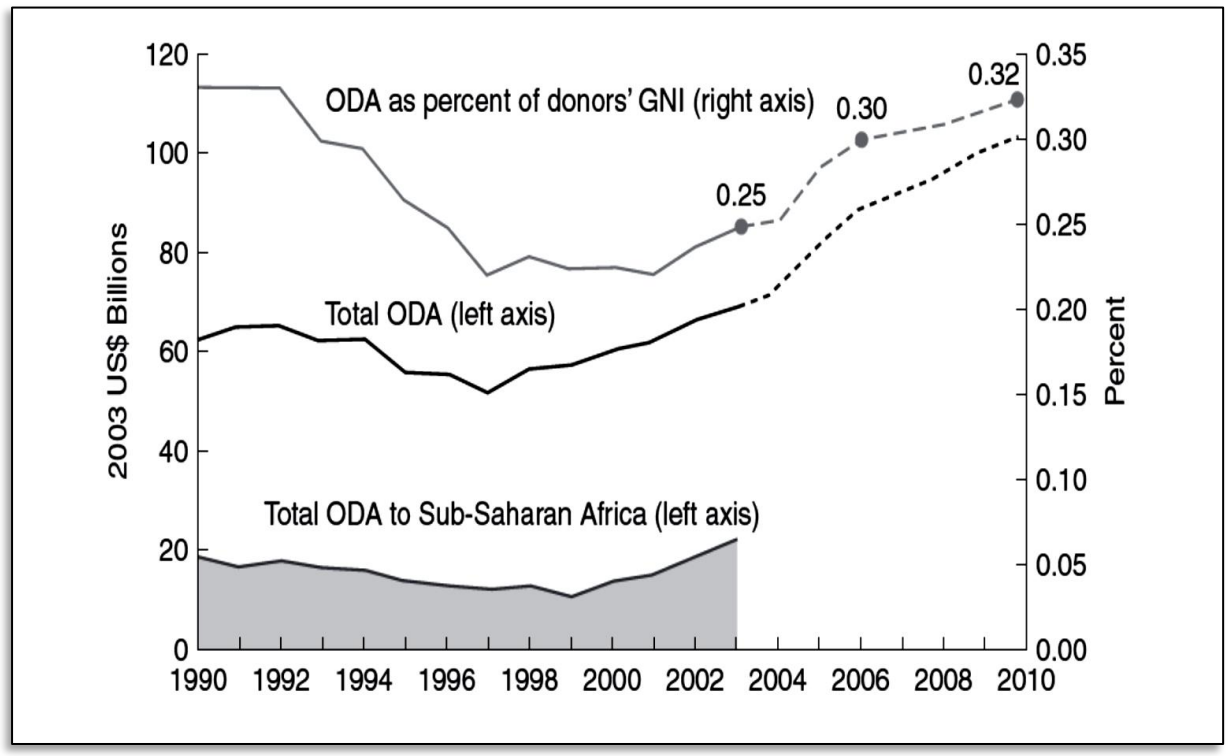
The share of ODA for health also grew from 1990 to 2000; an increase from 2% to 8%. Since 2004 the portion of ODA for health has fluctuated between 7% in 2006 and 12% in 2007. However by 2010 health ODA was greater than 12% of the total ODA. Trends in DAH were not always reflective of the patterns of ODA (IHME 2012)

Table 2:Total ODA and DAH (US$) 1990-2011

	Baseline	End Moderate-growth phase	End Rapid-growth phase	Beginning No-growth phase
YEAR	*1990*	*2001*	*2010*	*2011*
DAH	$5.7 billion	$10.8 billion	$28.2 billion	$27.4 billion
ODA	$99.0 billion	$92.2 billion	$148.4 billion	$146.6 billion

Source: OECD-ODA, 2012 Dec 17. http://stats.oecd.org/Index.aspx?datasetcode=TABLE1#

Figure: 2. Actual and Projected Official Development Assistance (1990-2010)



Source: World Bank 2005

3.2.1.2 Trends in flow of donor funds ODA and DAH (Nature and volume)

Tracking donor funds (ODA &DAH) provides decision makers and other global health stakeholders overview of how much is devoted to health and its impact. Global and financial crisis continue to have an impact on the trend of aid flow (ODA & DAH). Most donor governments are cutting down budgets especially the

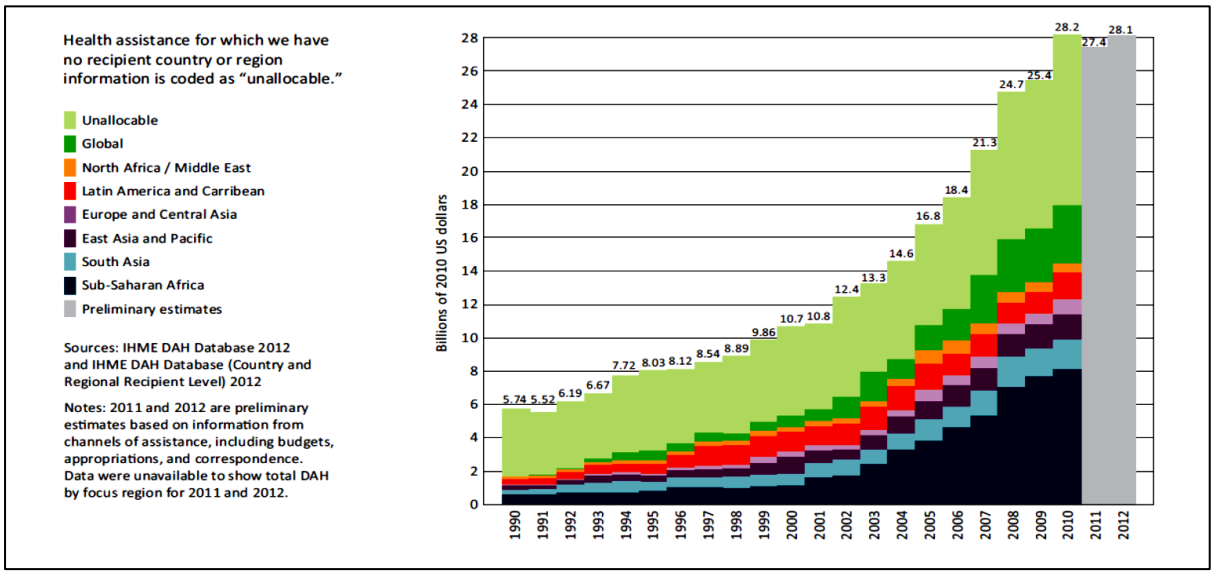
OECD-DAC member countries. Few are meeting the 0.7%[2] Gross Domestic Product (GDP) aid spending target (IHME 2012). The DAH channels are further reviewing policies and practices to adapt to the new global health financing strategies, amidst a Global Burden of Disease shifting to new epidemiological profiles. The global population now suffers most from Non Communicable Diseases (NCD's) and injuries (IHME 2012).

As a result, DAH is becoming unpredictable in terms of volume and timings. NGO's working in health only deliver humanitarian services; termed "basic Services." This short-term development aid commitments are not effective tools for delivering long term development programs.

Global DAH amounted to US$28.2 billion in 2012, with support from Bilateral and multilateral organization like UN, Public-private partners, World bank and foundations. Sub-Sahara African region received the largest share $8.1 billion or 28.7% of the total DAH, and DAH allocated to specific health focus like HIV/AIDS, tuberculosis, and maternal, newborn and child health continued to grow through 2010.

DAH transfers to governments as part of total government spending on health is less than 10% but however in Sub-Sahara Africa this amounted to more than half of total government health expenditure (IHME 2012).

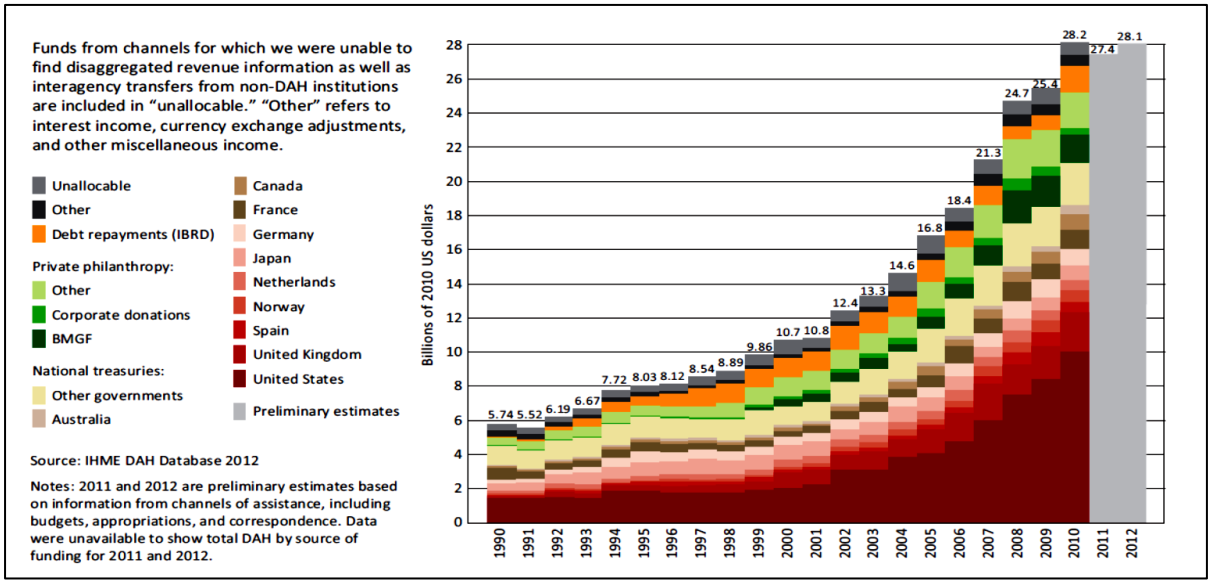
Figure:3. DAH by focus region, 1990-2010.



Source: IHME 2012

[2] First pledged 35 years ago in a 1970 General Assembly Resolution, the 0.7% target has been affirmed in many international agreements over the years, including the March 2002 International Conference on Financing for Development in Monterrey, Mexico and at the World Summit on Sustainable Development held in Johannesburg later that year.

Figure:4. DAH by source of funding, 1990-2010.



Source: IHME 2012

3.2.1.3 Trends of Aid to Post-Conflict regions

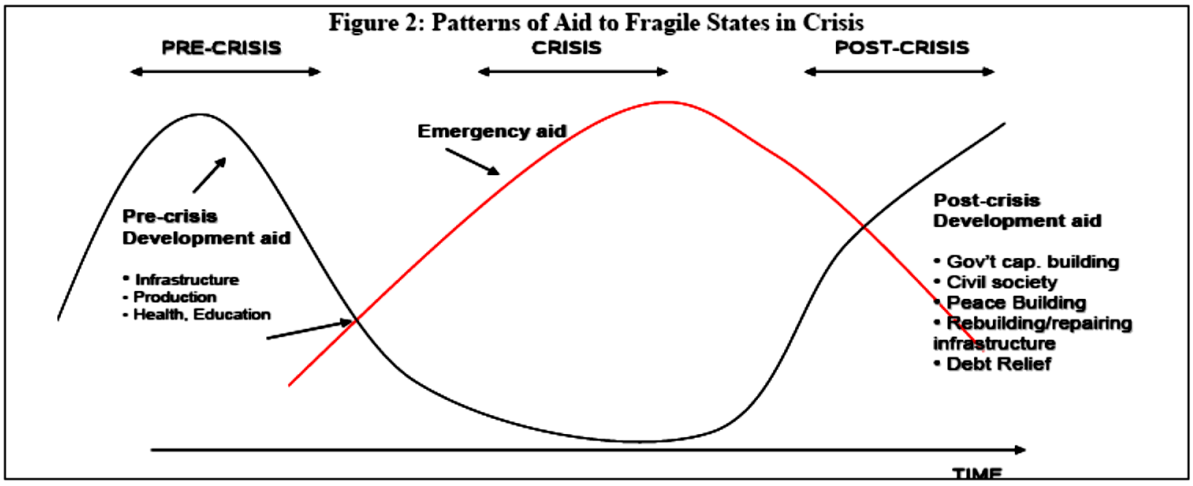
Post-conflict countries are "fragile countries" in terms of Aid flows. they experience much higher volatility in Aid flows, Post conflict regions receive less than 40% per capita as compared to performing countries, due to reduced Aid flows from Bilateral Donors. Fragile countries are "Aid darlings" if they receive higher Aid flows than predicted by poverty and policy, while others are "Aid orphans" if they receive substantially lower Aid flows despite predicted poverty and policy requirements (Capabianco & Naidu 2012).

The Millennium Development Goals (MDG's) agenda is an additional push for higher health investment in post-conflict countries, where 14% of the world population and one third of world's poor live. Investment in the health sector is vital because this can alleviate human suffering, support the country's peace process and provide sustainable returns in terms of equity efficiency, and effectiveness of services.

Furthermore, health investment in post-conflict countries should be supported because of severe health statistics. Fragile countries contribute to 60% of global disease epidemics; 1/3 of global maternal deaths; 1/3 of people living with HIV in developing countries; 50% of children dying before 5 years of age; Malaria death rate 13 times higher than other developing countries; and High malnutrition rates 1/3 of total population (Capabianco and Naidu 2012).

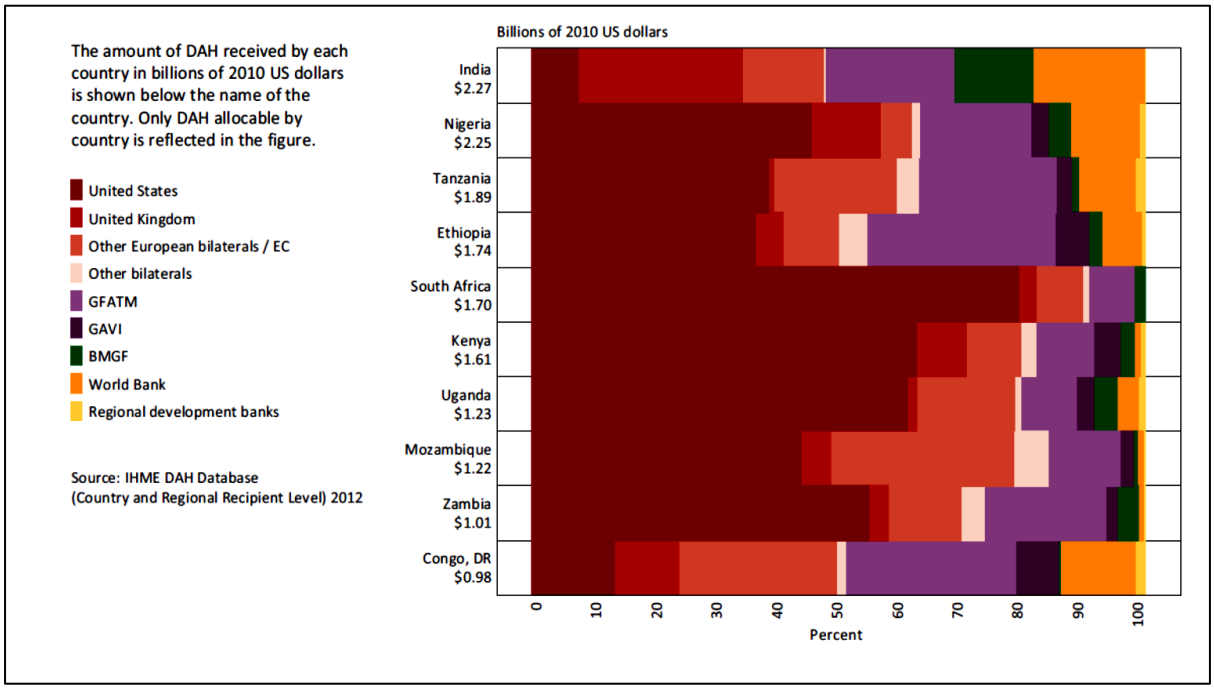
(Witter. S, 2012), noted that "priorities in aid to the health sector in post-conflict regions, tend to be set on the basis of donors' political needs rather than on the objective needs of people in distress".

Figure:5. Patterns of Aid flow in fragile countries



Source: KIT 2008

Figure:6. Top 10 recipient countries of DAH by channel of assistance, 2008-2010.



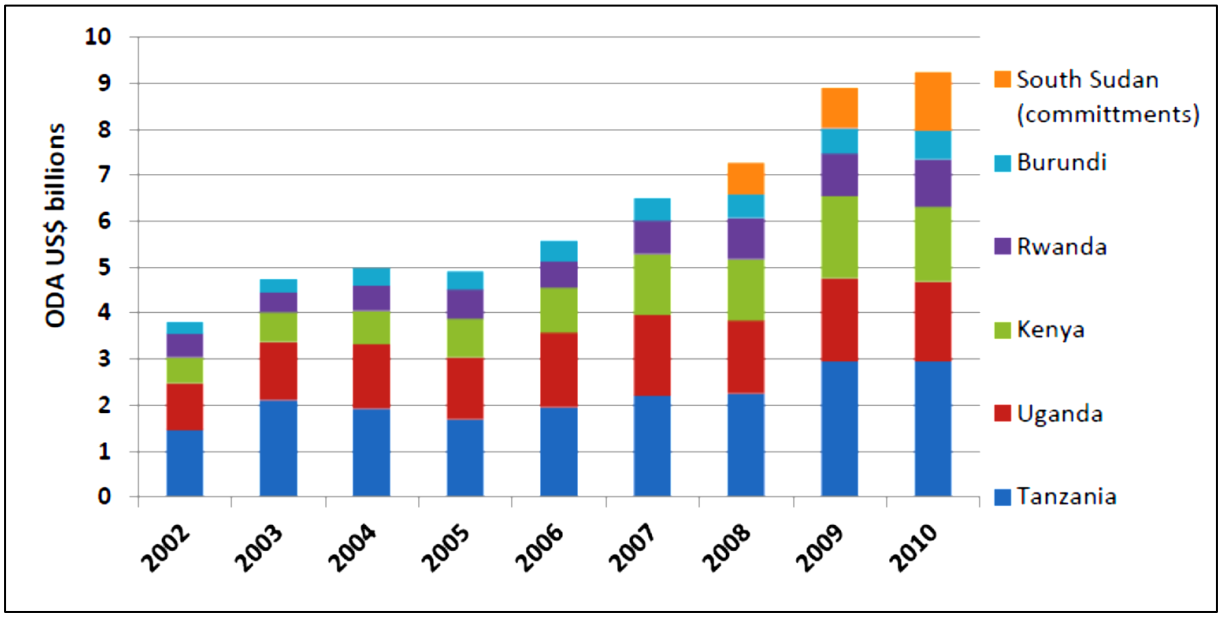
Source: IHME 2012

3.2.2 National

3.2.2.1 Trends of ODA and DAH to South Sudan

Official Development Assistance (ODA) is an important source of financing in RSS. No data exists for the country in the OECD DAC data until Dec 2012, the information is obtained from National Bureau of Statistics and MoFEP, indicated that ODA flows increased from US$696.5 million in 2008 to US$1.3 billion in 2010, and dropped to US$937.2million in 2012.

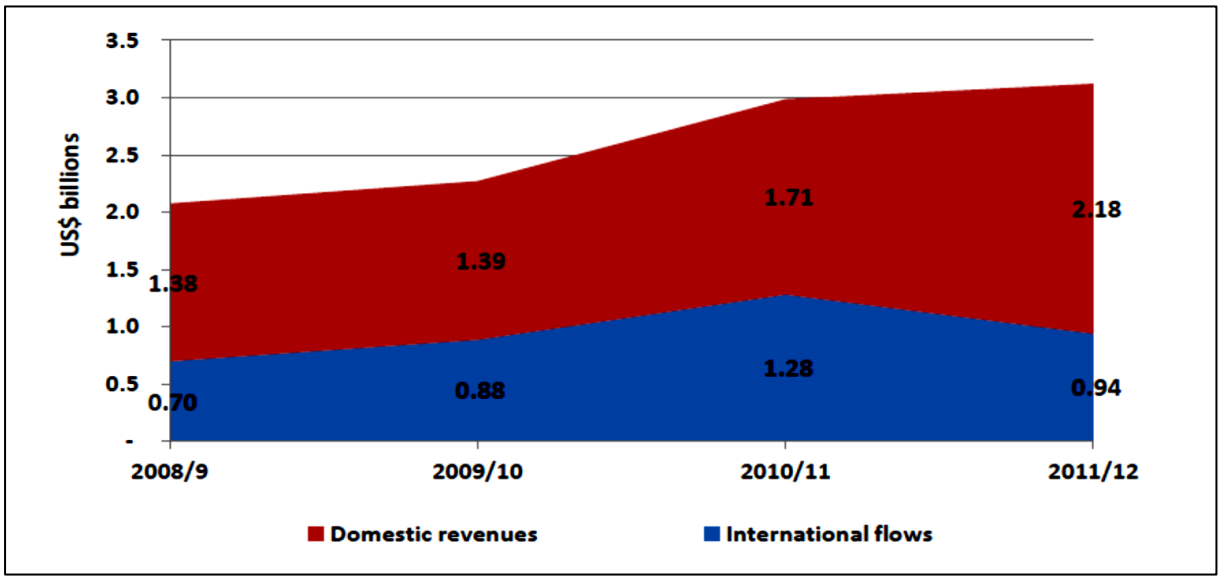
Figure:7. ODA to South Sudan compared to other East African Countries



Source: Development Initiatives on OECD-DAC & National Bureau of Statistics S.Sudan

The same source also reveals that between 2008 and 2011, US$3.8 billion worth of commitments were made to South Sudan. This was equivalent to about 57% of the US$6.7 billion worth of domestic revenues committed for expenditure on public policy in the same period. However, these figures are still very low compared with other East African states – Kenya, for example, received US$4.7 billion, an increase of 23% in the same period while Tanzania is the largest recipient in the East African region received about US$5.2 billion (Okwaroh. K 2012).

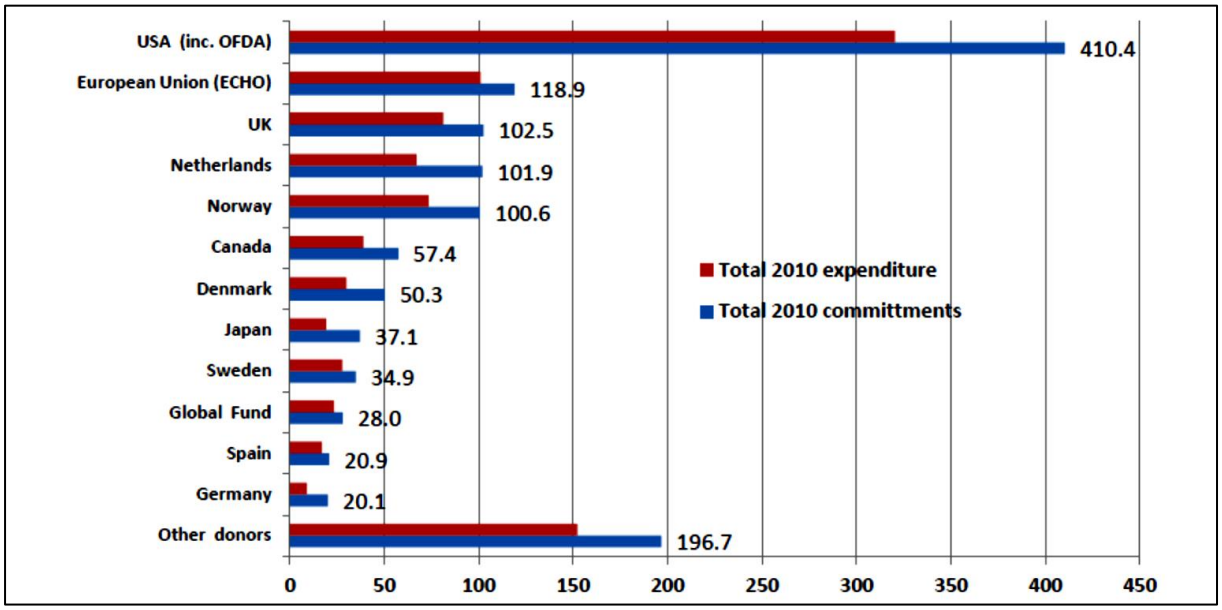
Figure:8. Foreign Aid commitments and domestic revenues



Source: Development Initiatives & National Bureau of Statistics S.Sudan

There are marked disparities between commitments and disbursements, which are sometimes up to 50% less, and donor priorities do not seem sufficiently synchronised with GoSS expenditure priorities and funding needs. In 2010, for example, 25% (US$319.4 million) of total commitments were not disbursed as promised.

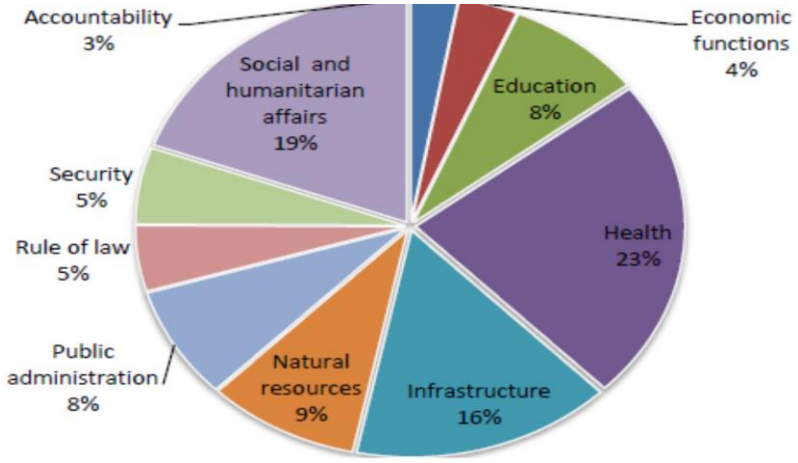
Figure:9. Top Aid Donors to South Sudan.



Source: Development Initiatives & National Bureau of Statistics S.Sudan

Between 2008 and 2010 the health sector received about 23.0% of the total proportion of ODA (18.6% on average annually). Most Donors channeled funds through multilateral institutions and pooled funds. They include Global fund, World Health Organization (WHO), Basic Services Funds (BSF), Common Humanitarian Funds (CHF) and the Multi Donor Trust Funds (MDTF). The US is the only Bilateral donor between 2008 and 2010 that fulfilled her commitment of US$584 million to the health sector. In 2010 US$178.6 million from ODA was spent on health, the Government of South Sudan (GOSS) spent less than 50% of domestic resources to health. The per capita ODA in health was US$9.90 in 2008, US$8.80 in 2009, and US$6.90 in 2010; showing a decline in the amount of ODA that is spent per person on health in South Sudan (Okwaroh. K 2012).

Figure:10. ODA Distribution by sector 2008-2011.



Source: Development Initiatives & National Bureau of Statistics S.Sudan

3.3 Actors

Global resources for improving health have improved and increased in low-Income and middle-income countries. In addition to traditional Bilateral agencies, multilateral organizations, public-private partnerships, INGO's; new global health players have emerged, including the Bill & Melinda Gates Foundation, the GAVI Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Tracking flow of DAH begins with international agencies and institutions whose primary purpose is to provide development assistance and are referred herein as *Channels of assistance*, they include:

Bilateral donor agencies: (USAID, DFID etc)-these extend aid directly to governments or Non-government actors.

Private actors: private foundations (BMGF)-these donate to institutions to undertake health program/research and INGO's who receive funds from donor governments, corporations, and individuals to finance health programs/research.

Multilateral agencies: Including UN agencies (WHO, UNICEF, UNAIDS, UNFPA)-these receive from public and private sources to give financial/technical assistance and policy guidance in health; the

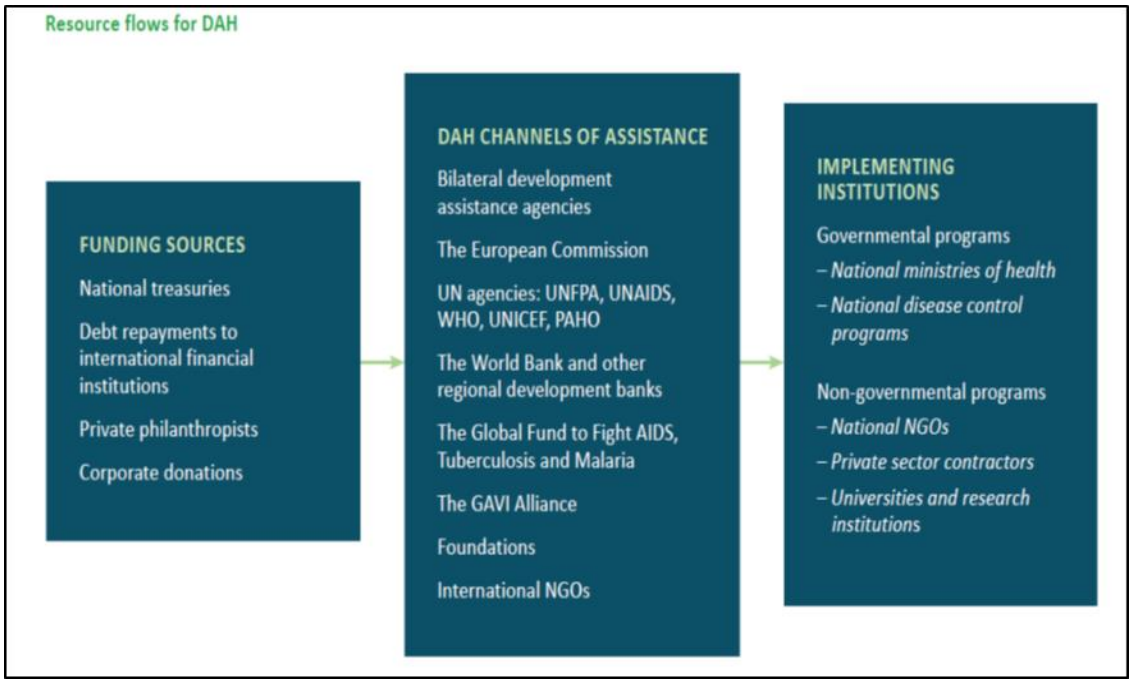
World Bank: The World Bank receive from donor countries and invest in capital markets which in turn are used for financing health.

European commission (EC) which is the executive arm of the European Union (EU) that extends aid to developing countries.

The Global health initiatives (GFATM & GAVI)-act as public-private partnerships and extend disease-specific funding.

The channels of assistance transfer this assistance to *Implementing agencies/institutions*, which include: Ministry of Health (MoH) and Ministry of Finance (MoF) of national governments and other implementing partners (INGOs, CBO's, FBO's) who support health programs/research at the beneficial level in form of financial or in-kind contributions. The channels of assistance differ in terms of funding sources and revenues and they receive funds from national treasuries, private philanthropists or corporations; the global Channels of assistance sometimes directly finance developing countries in form of loans or grants and provide technical assistance, policy guidance and disease surveillance.

Figure:11. Resource Flows for DAH



Source: IHME 2012

3.3.1 Funding sources

Under the National treasuries most donor governments are cutting down budgets especially the OECD-DAC member countries due to the financial crisis; few are meeting the 0.7% Gross Domestic Product (GDP) aid spending target. No data is available on other funding sources like the private business corporations e.g. Shell, Toyota etc who sometimes fund NGOs directly.

3.3.2 DAH channels of assistance

The United States is the largest bilateral donor (see Fig 9 above), although multilateral funding is increasingly becoming a favoured means of aid delivery. Between 2008 and 2011, the majority of aid to South Sudan was from the US (US$420 million), followed by the European Union (EU) US$ 118.9 million, United Kingdom (US$102.5 million), the Netherlands (US$ 101.9 and Norway (US$100.6million) (Okwaroh. K 2012). These sources of funding could also be

linked to geopolitical and economic interests in the country especially in terms of oil revenues.

3.3.3 Implementing Institutions

The main implementing institution is the government of South Sudan. Her major ministries of Health, Finance and Economic Planning, and Ministry of Education (MoE) that manage the human resources for health capacity under the training institutions. The government has disease specific programs like the National program for integrated control of neglected diseases (NTDs),National malaria control program etc.

According to NGO Forum report 2010; in 2005 there were approximately 47 international NGOs working in Southern Sudan. In 2010 there were over 155 international NGOs registered and equally as many national NGOs and Faith Based orgnaisations (See Annex 4), delivering humanitarian services, now considered 'basic services,' including water and sanitation, health care, and education.

The global initiatives (GFATM & GAVI), implement vertical programs in the country, and are part of the implementing institutions.

Private sectors contractors like Crown Agents, Jhpiego, Abt Associates, Mott Mac Donald are usually hired by NGos to manage funds on their behalf as implementing agents.

3.4 Process

3.4.1 Financing Mechanism

Prior to the signing of the CPA 2005, foreign aid assistance was provided through Operation Life line Sudan (OLS), that began in 1989. International Non-Governmental Organization (INGO's), Faith based Organizations (FBO) and local NGO's supported health facilities remotely. This was defragmented and uncoordinated in range of geographical areas, leaving many zones underserved (Hutton K. 2013). Currently health coverage is estimated at 25% of total population and there is lack of uniformity in the level, type or quality of services. Geographical equity exists with facilities to population ratios; with the highest in Bahr-el-Ghazal and lowest in Equatoria; a case in point, the USAID's " Health Transformation Project that was meant to serve 20 counties but only reached 6 counties (Willem C and Waldman R, 2006).

A combination of planning and Aid coordination frameworks were instituted before and after CPA, these included: Joint Needs Assessments; Transitional Result Matrix (TRM) and consolidated appeals. In May 2003 a Joint Planning

Mechanism was created under USAID, WB, UN agencies, and IMF which pledged nearly $2billion to meet the priorities and the action plans drawn. The Multi Donor Trust Fund for South that came to operation in June 2005 managed these funds. The first MDTF money was disbursed in late November 2005, providing a $27million emergency package to rebuild health and education services, and to support basic government functions in South Sudan.

In January 2004, prior to the formation of MDTF-South Sudan, the SPLM had established the Capacity Building Trust Fund for South Sudan to fund only recurrent health costs (IRIN, January 18 2006). Later the same year, the SPLM developed a health sector strategy (SoH & SPLM, 2004) that outlined key priorities and ushered a foundation for the joint needs assessments.

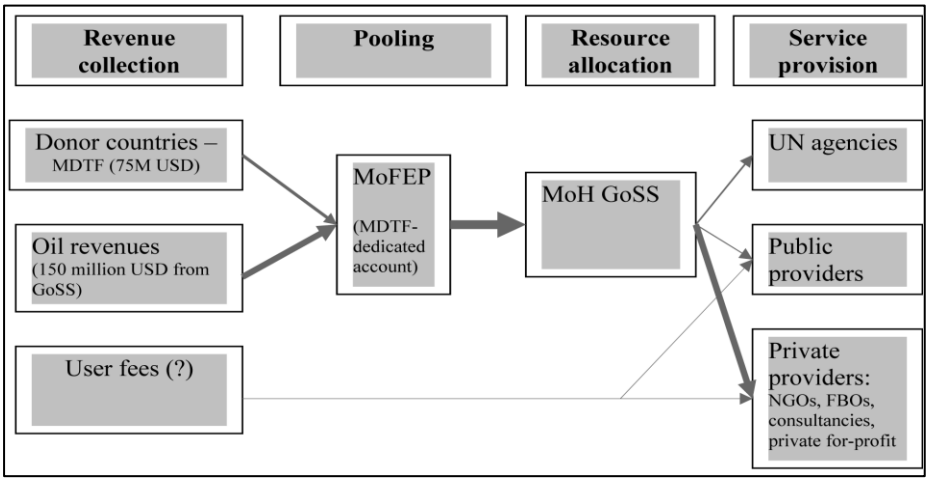
The Joint Assessment Mission (JAM) for Sudan started its work in January 2004, assessing needs as well as developing a longer framework for recovery and reconstruction. The JAM was guided towards the "then" region's MDG's. JAM resulted in the framework for Sustainable Peace Development and Poverty Eradication, which was endorsed by key stakeholders in Oslo in April 2005. Subsequently, JAM's health sector needs assessment ushered the South Sudan Health sector Working paper, which drew the SPLM's 2004 Strategy for the Recovery of the Health sector and was incorporated into JAM's Basic Social Services Cluster Report (Fenton. W, 2008).

The major umbrella mechanism for donor coordination, by then, was the Sudan Consortium. It was aimed at achieving national consensus on Humanitarian and reconstructing strategic priorities and the review of overall development programs.

After the CPA, GoSS MoH formulated a new interim health policy that outlined goals for 18 priority areas for a six-year interim period. The MoH policies held five core values: right to health, equity, pro-poor, community ownership and good governance. It has a clear mission of ensuring " equitable, sector wide, accelerated and expanded quality health care for all people in South Sudan especially women and children" (Willem C and Waldman R, 2006). However, these early policies were not realistically aligned with actual field conditions and could not be put into operation.

Prior to CPA in South Sudan, severe discrimination in health services provision happened on political, social and geographical levels. Sudanese women issued a declaration during the Oslo conference, calling on donors to commit to the "principles of gender response to resource allocation;" so that 80% of reconstruction budgetary allocations and resource support directly benefit women, reduce gender inequities, benefit youth/adolescents, and targeting rural communities. They further demanded that, as a follow up of donor commitment, a Sudanese women conference be organized to define a long term agenda in achieving gender equality (Downie. R, 2012).

Figure:12. Health Financing structural mechanism in South Sudan.



Source: Giorgio.C, Gyuri. F and Egbert.S 2010

3.4.1.1 External financing mechanisms

These funds operate directly not through pooled system and they sometimes implement vertical programs alongside with the government of South Sudan.

Global Health Initiatives

Global Fund: South Sudan has received grants from Global fund to fight HIV, TB and Malaria programs since 2008 (See Table 3). Approval for further funds for HIV $30.5 and Malaria $18.3 in phase II are available, while TB grants are ending 2013 (Fox. S and Manu. A 2012)

Table 3. South Sudan status of global grants to date.

Component (Round)	Grant title	Principle Recipient	Start date (Current Phase)	End Date (current phase)	Total Budget US$	Amount Disbursed	Last updated on
Malaria(7)	Scaling-up coverage , prevention & control	PSI	01/12/08	30/11/13	33,512,896	46,229,289	18/5/11
TB (7)	Improving & expandingTB control	UNDP	31/12/10	31/12/13	5,000,208	2,606,313	22/11/11
HIV/AIDS	Health systems strengthening	UNDP	01/10/10	30/9/12	22,056,398	16,311,744	11/8/11

Source: http://www.portfolio.theglobalfund.org/en/Search/PortfolioSearch#

Global alliance for Vaccination and Immunization (GAVI):

On approval of the Immunization Services Support (ISS), South Sudan received funds for beginning 2007 and currently no funds are approved beyond 2012 (See Table 4).

Table 4. Total annual commitments & disbursements by category 2007-2012.

	2007	2008	2009	2010	2011	2012
Immunization Services Support						
Commitments	$1,193,449	$1,019,125	$2,038,250			$84,500
Disbursements by Programme year	$1.193,449	$1,019,125	$2,038,250			
Health systems strengthening						
Commitments			$2,268,000		$2,707,00	
Disbursements Program year			$2,607,654			

Source: http//www.gavialliance.org/country/sudan.

3.4.1.2 Internal financing mechanisms

The funding mechanisms below started in 2005 and by 2012 most of them had ceased to operate.

The pooled funds include the following:

Basic Services Fund (BSF)[3]: This fund was established in 2005 and managed by Mott MacDonald targeting primary education, primary health, water and sanitation. It is funded by Department for International Development (DFID); European Union (EU);Government of Netherlands (MINBUZA); Government of Norway (NORAD)and the Swedish International Development Agency (SIDA). 37 NGO's, either in consortium or independently, provided health service delivery at PHCC and PHCU levels (salaries, incentives, drugs, equipment, training & maintenance). BSF has received about US$40million by the close of the pool in 2012.

Multi Donor Trust Fund (MDTF)[4]: This fund was established in 2005 and administered by World Bank (WB). It was funded by bilateral (Canada, Denmark, Finland, Germany, Iceland, Italy, Norway, Spain, Sweden and the UK) and Multilateral (World Bank and EU) donors. Through the Umbrella Program for Health System Development (UPHSD), it focused on MoH capacity bulding, investment in infrastructure/equipment, expansion of basic health services and human resources development. Two NGO's Norwegian Peoples Aid (NPA), IMA world Health, plus HLSP/Mott Mac Donald delivered the services. MDTF managed about US$700million till its closure June 2012.

Common Humanitarian Fund (CHF)[5]: This fund was established in 2005. It was managed by UNDP's Multi-Partner Trust Fund office, directed to meet critical

[3] http://www.bsf-south-sudan.org/
[4] http://mptf.undp.org/factsheet/fund/SRF00
[5] http://www.unocha.org/sudan/humanitarian-financing/common-humanitarian-fund

humanitarian needs. From inception in 2005, CHF had disbursed approximately US$734.3 million by closure of the fund in 2010. It was supported by DFID, SIDA, Belgium government, Australia Aid for International Development, Irish Aid, Denmark government, Norway and Netherlands government.

Sudan Health Transformation Project (SHTPII): This fund started in 2009 and ended in 2012. It was intended to expand access and coverage through support to community Health Departments (CHD's). it was managed by Management Sciences for Health (MSH) towards development. It covered 14 counties in all 10 states.

Office of U.S Office Foreign Disaster Assistance(OFDA): this fund supported approximately 182 health facilities in 25 counties with 12 NGO's delivering service, the fund closed end of 2012.

Planned funding and implementation modalities

This new funding and implementation modalities 2012-2016, are reached on the grounds that the previous funding mechanisms were short-term, many funding streams are coming to an end by 2012 and donors lacked joint co-ordination and collaboration which has not anchored sustainable services for the country. This time, the arrangement reflects geographical distribution of resources.

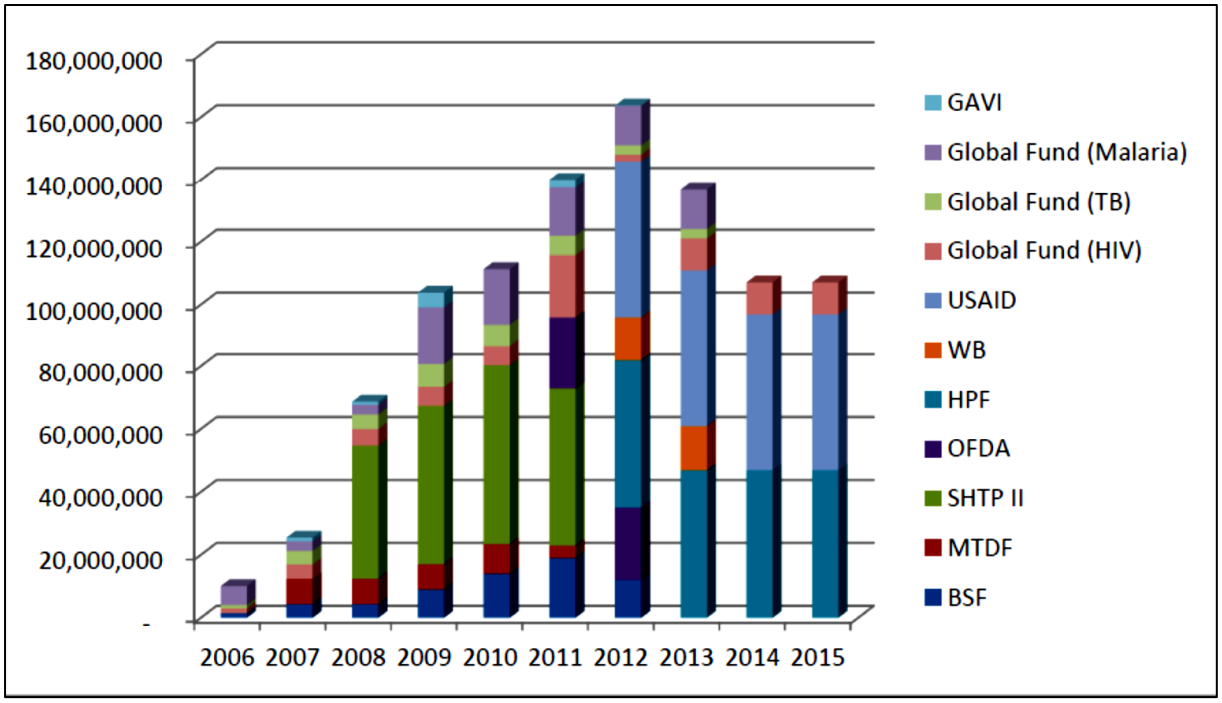
Table 5. Planned funding modalities 2012-2016

Funding Modality	Donor	Lead Agent	Health Focus	State/County	Pledged Amount($)
Health Pooled Fund (HPF) Start date 2012 & End year 2016, a 5 years project *This has been piloted in Medit*erranean region by DHS-EMRO	CIDA, AUSAID,EU, SIDA, DFID	Crown Agents (consortium of 6 agencies)	• Maternal & child health services • Improved community governance • Supporting health services strengthening	Unity, Lakes, Warrap, Eastern Equatoria, Western & Northern Bahr-el-Ghazal 39 Counties	£150 Million Approx. $250 million
Rapid Results Health Project (RRHP), Jan 2012-Dec 2013 a 12 months project	World Bank (WB)	IMA	• Improving health services delivery • Capacity strengthening at local level (CHDs) • Performance based financing (PBF) focus M&E on grants/contracts managmgnet	Upper Nile & Jonglei 5 CHD's (Melut, Manyo, Renk,Akoka &Malakal	$23 million

Integrated Service Delivery Project (ISDP) and **Health Systems Strengthening Project (HSSP)** started 2012-2016, a 5 years project	USAID	Jhpiego + 5 NGO's for ISDP Abt Associates + 6 NGO's for HSSP	• Basic Package of health services (Training, Support supervision & Rehabilitation, salaries • Health systems strengthening- Meternal & Child Health Intergrated Program-MCHIP in SMoH, CHD's PHCC's)	Central and Western Equatoria 16 counties	$85 million for Health services delivery $25 million for Health systems strengthening

Source: Kate Hutton, April 2013.

Figure 13. Overview of Donor funding for health sector 2006-2015



Source: Fox S. & Manu Alex 2012.

3.4.2 Allocations of funds

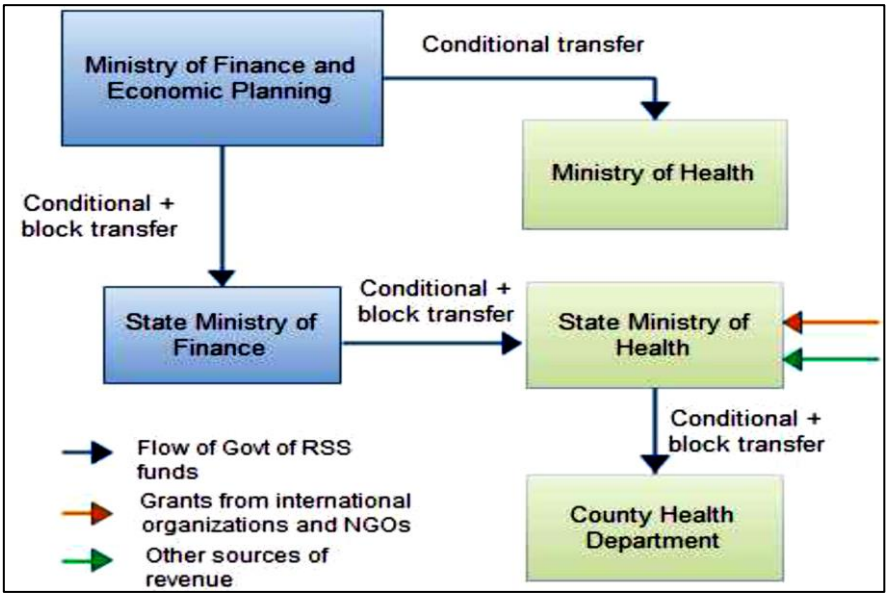
The influence of DAH on Government health Expenditure

Like in all other sectors of government, the Government of South Sudan derives revenue, mainly from oil and taxation (See Fig 15, pg: 27), to fund the health sector. However, DAH remains a major source of funds to support the health sector.

The national health insurance system is only accessible by a small proportion of the government civil servants, and Primary health care is offered free of charge to the entire population. Though there is unreliable evidence of out of Pocket(OOP) expenditure especially among urban population making an additional contribution to the total health expenditure, both government revenues and DAH are declining since 2006 and are now insufficient to fund the health priorities as outlined in HSDP.

South Sudan Ministry of Health (MoH) system is devolved in 4 levels; providing health care services based on "Continuum of care" principle. This decentralized structure is in accordance with the decentralization policy of the interim constitution of South Sudan (2005), the transitional constitution of South Sudan (2011) and the Local Government Act (2009). A portion of the health budget is transferred from MoFEP to State Ministry of Finance (SMoF) and allocated to SMoH in form of conditional grant earmarked for (salaries, operating & capital expenditures). Block grants are not earmarked but used by SMoH according to their priorities.

Figure 14. Flow of funds in the health sector

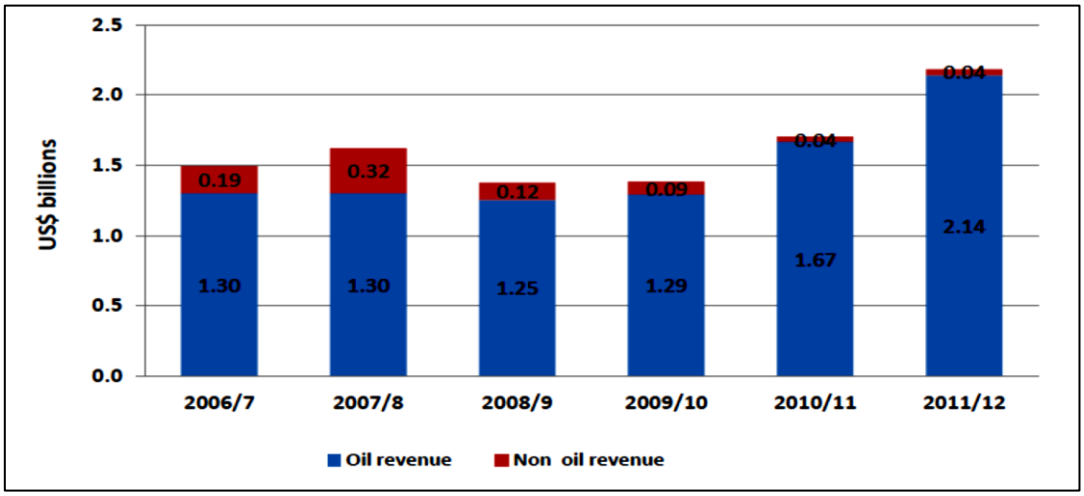


Source: Fox.S & Manu.A 2012

Expanding government expenditure and declining revenues.

As seen in (Fig.16, pg: 27), the average total spending of domestic resources as a percentage of the country's Gross Domestic Product (GDP) increased from 11.2% in 2008 to 14.8% in 2010; however since 2006 to date the government over depends on revenues from oil exploitation, despite efforts to strengthen the tax regime to generate non-oil-revenues. Comparatively on average, tax and other non-oil revenues as a proportion of total national revenue are about 2.6% in South Sudan, compared with 13.4% in Rwanda, 13.0% in Uganda and 17.2% in Kenya over the same period (Okwaroh. K 2012) .

Figure 15. South Sudan domestic revenues



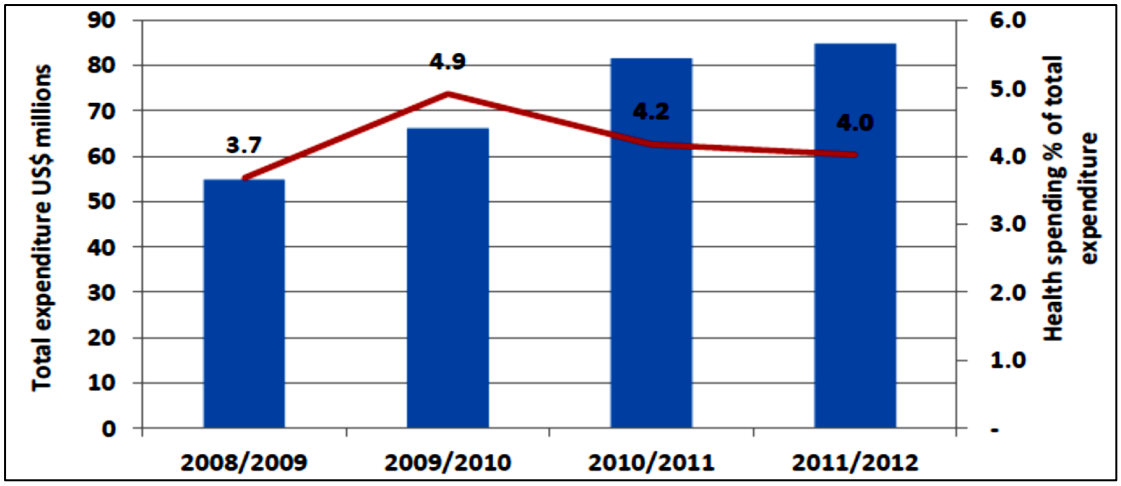
Source: development Initiates-SSNBS 2012

Under funding Essential sectors of the Economy

In South Sudan, the three essential public sectors (Health, Education and agriculture) remain under funded, by annual budget allocations (See Figure 17, pg:28). From 2008 to 2012 revenue expanded by 17.2%, and yet total expenditure on these sectors received collectively only 12.5% of the total average spending, compared to security which received a 28.2% boost, Infrastructure 16.9%, Public administration 11.5%, Justice, law and order 11.4% (SSBS 2012).

Expenditures of these essential sectors fell short of international standards and targets set by the 10 states. This unequal distribution of funds across sectors demonstrates a lack of resource prioritization to local needs.

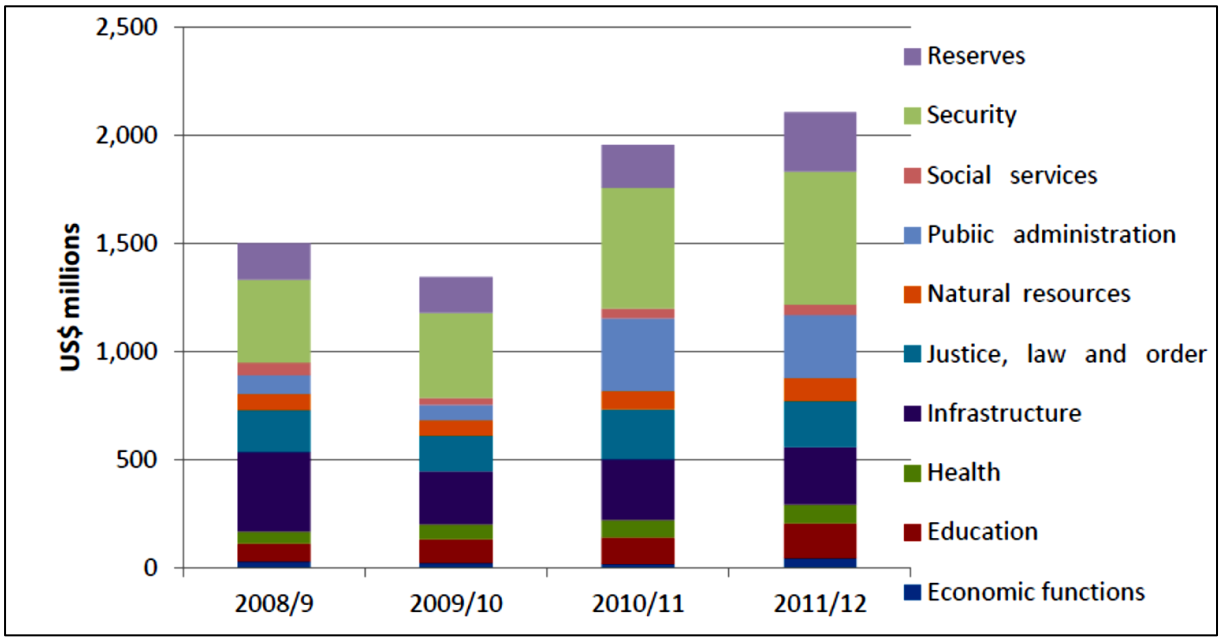
Figure 16. Health sector spending as a proportion of total expenditure



Source: Development Initiative & SSNBS 2012

Alhough there is an increase in volume of allocations to the health sector from $54.9million in 2008 to $84.9million, in 2010 (a 1.2% rise), the increase still remains far below the 15% target[6].

Figure 17. Government expenditure by sectors



Source: Development Initiative & SSNBS 2012

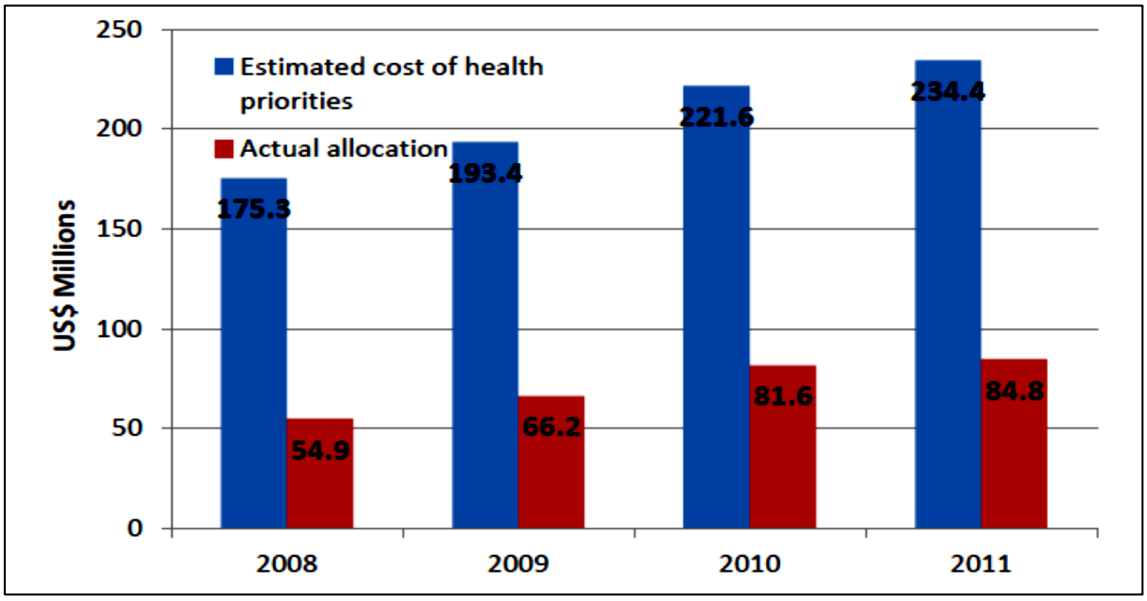
Aligning resources with expenditure priorities is challenging because budget allocations and donor commitments do not sufficiently reflect identified priorities. Example education and health received proportionally lower total spending of 6.9% and 4.2% respectively compared to other sectors like Security (See Fig 16, pg:29), yet they are considered priority expenditure areas by the South Sudan priority expenditures 2008-2011.[7] Lack of prioritization also shows lack of harmonization between the GoSS expenditure priorities and those of donors.

In (figure 19, pg:29), it show expenditure of domestic revenues by health sub-sectors. Secondary and tertiary health care which are referral received 32%, while primary health care which is the basic received 7%. Health systems development only received 5%; moreover there is the problem of lack of capacity in the health sector.

[6] The 15% target was set by the African Union (AU) heads of state in 2001 during the Abuja Declaration in2001.

[7] The South Sudan priority expenditure 2008-2011, that identified Security, Roads, Primary health care, Education, Water and production, improving rural livelihood/income as six major priority expenditures to have first call on budget resource allocation between 2008 and 2011.

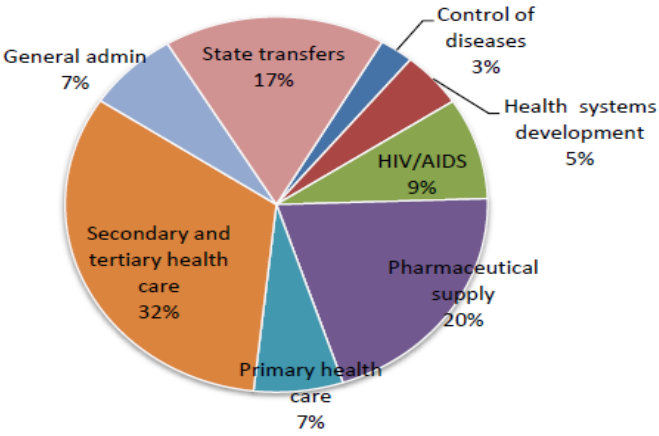
Figure 18: Estimated cost of funding priority expenditure Vs actual allocations.



Source: Development Initiative & SSNBS 2012

Low levels of health expenditure in the different health subcategories may reduce the country's ability to achieve certain targets such as increasing basic health services coverage by 50% of the total population, reducing infant and maternal mortality rate by 25% and increasing routine immunization coverage to 90% by 2011.

Figure 19. Expenditure of domestic revenues-by health sub-sectors.



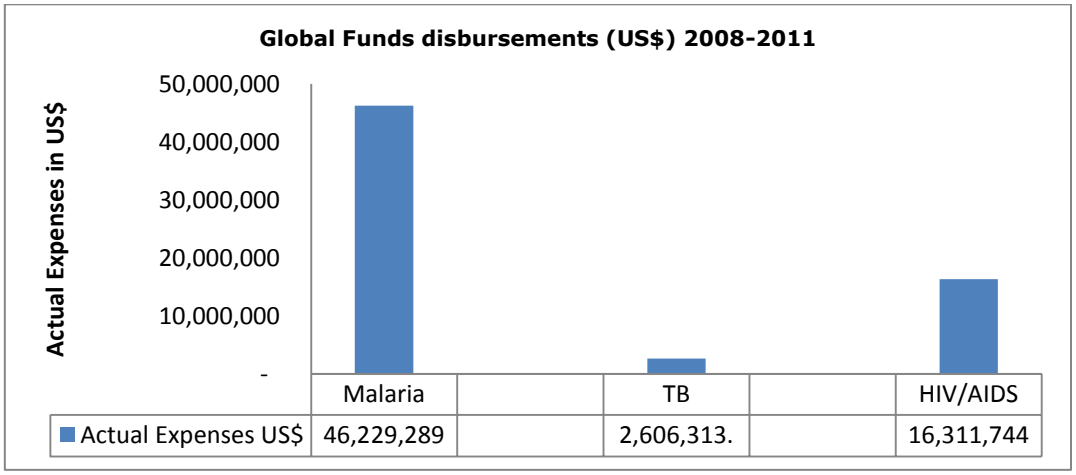
Source: Development Initiative & SSNBS 2012

3.4.2.1 Allocations by disease groups

Data on specific disease expenses by various Donors in South Sudan could be found. It can be deduced only from the Global initiatives on Table 3 &4 (See pgs: 22 & 23) for Global fund and GAVI whose data was readily available.

Most NGO's designed their health programs or interventions to focus on factors affecting health (determinants of health) like: improving access to safe water and sanitation facilities; to improve access to enhanced quality of education and alternative learning opportunities, and malnutrition/emergency therapeutic responses.

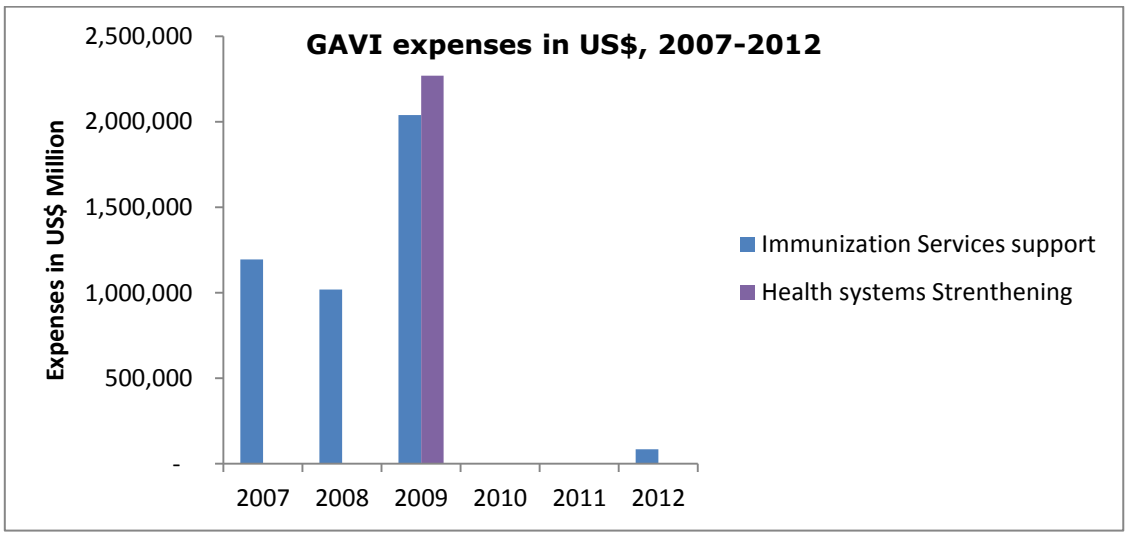
Figure. 20:



Source: *http://www.portfolio.theglobalfund.org/en/Search/PortfolioSearch#*

in the graph (Fig. 18) and Table 3. The Global fund, since inception, spend more money on Malaria (about US$ 46Million), from 2007 to 2012 in South Sudan, followed by HIV/AIDS (16Million), while the TB program received about (US$2.6million).

Figure. 21:



Source: *http//www.gavialliance.org/country/sudan.*

In table 4. & Fig 19. GAVI spent more on actual immunization about US$2.6miilion as compared to Health system strengthening for immunization.

3.4.2.2 Geographical equity

Health Equity is defined as "the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy" (Braveman and Gruskin, 2003). Sometimes health inequality is used interchangeable with health Equity, but it should be noted that health equity focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality. As an ethical concept health equity is based on the principle of distribution of justice and hence human rights.

The concept of health Equity in this paper focuses on ***Geographical Equity***, to mean geographical disparities in access to health care and health status. In the case of South Sudan the effect of conflict and security has an interplay in the degradation of health infrastructure hindering the ability of people to travel to access health services. There is geographical coverage deficit, resulting in an imbalance in the health system, where by the rural areas are underserved compared to the urban areas.

South Sudan Population density and poverty indices

Table 6. South Sudan population density 2006

State	Urban	Rural	Total	Area (sq km)	Density %
South Sudan	**1,405,186**	**6,855,304**	**8,260,490**		13
Upper Nile	243,976	720,377	964,353	77,283	12
Jonglei	129,341	1,229,261	1,358,602	122,581	11
Unity	120,790	465,011	585,801	37,837	15
Warrap	84,887	888,041	972,928	45,567	21
Northern Bahr El Ghazal	55,398	665,500	720,898	30,543	24
Western Bahr El Ghazal	142,945	190,486	333,431	91,076	4
Lakes	65,033	630,697	695,730	43,595	16
Western Equatoria	100,034	518,995	619,029	79,343	8
Central Equatoria	382,362	721,195	1,103,557	43,033	26
Eastern Equatoria	80,420	825,741	906,161	73,472	12

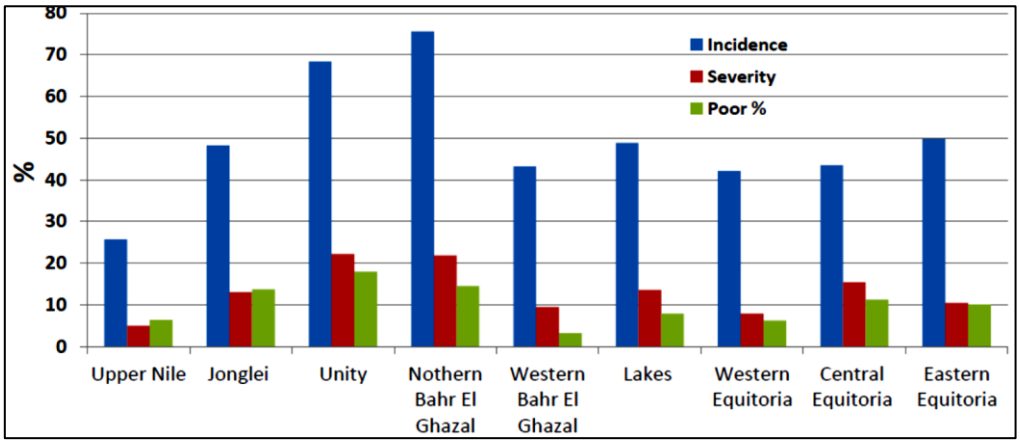
Source: SSNCS 2006

The NGOs operating in South Sudan provide "Basic services" on humanitarian basis and it is focused on "high priority states" and "high risk underserved"(NGO Forum 2012). Other considerations include areas where there are high numbers of Internal Displaced people (IDP's), returnees and high levels of food security (See Annex 4).

The population size and population density as seen in Table 6 are important factors in determining the provision of health services, that are considered as

variables in determining resource allocation formula and hence health equity can be achieved.

Figure 22. South Sudan poverty Indices



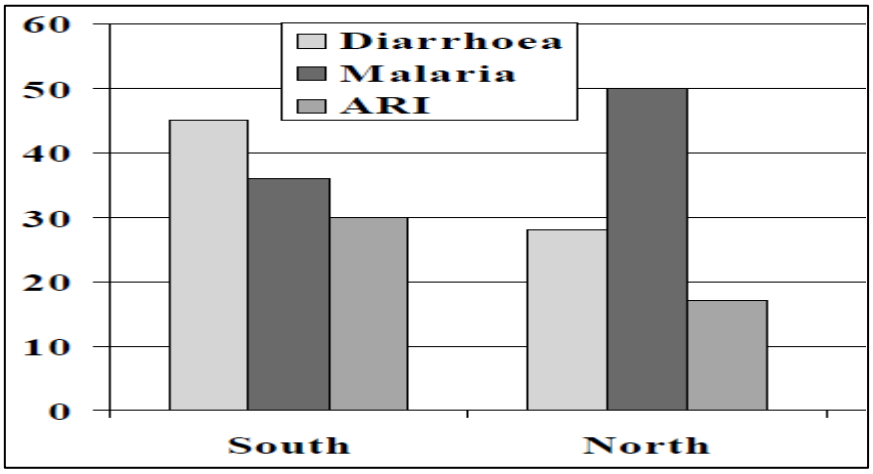
Source: SSNCS 2006

Per the NGOs criteria of resource allocation above, more fund, interventions and NGO concentrations is seen mostly in the two regions of Bahar-El-Ghazal (Northern, Western Bahr ghazal & Warrap) states, and Greater Upper Nile regions of (Jonglei, Unity, & Lakes) states (See Annex 4). While the Greater Equatorial region of (Central, Western & Eastern Equatoria) states remain underserved. Poverty indices (Seen Fig 20) is an important variable in determining equitable resource allocation.

Comparing Equity between South Sudan and Sudan

In comparison of South Sudan and Sudan (Fig 14) on the prevalence of childhood illness (%) among under 5 years in 2000, the differences between the two countries show systematic disparities in the determinants of childhood illness (Diarrhorea, Malaria & ARI).

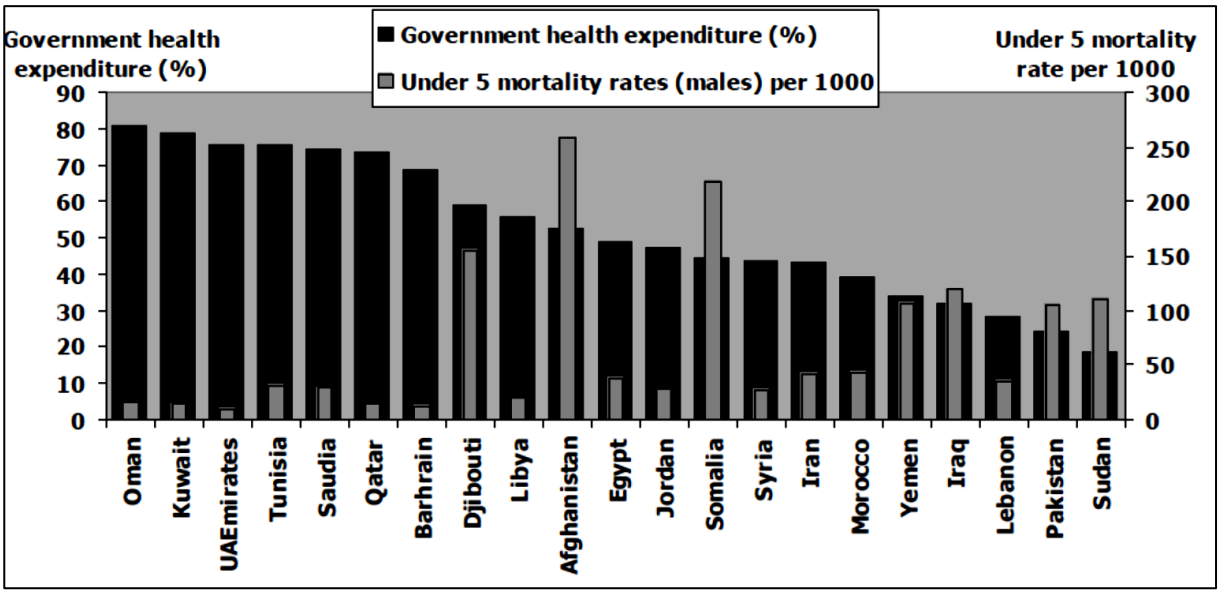
Figure 23. prevalence of childhood illness (%) among under 5 years in 2000



Source: NSCSE in association with UNICEF 2004

Comparing government health expenditure (%) as a total expenditure on health (%), with burden of diseases; a comparison can be drawn among the following countries from the United Arab Emirates (UAE). The higher the government health expenditure, the lower the under 5 mortality rates (Batniji, R. & Bendavid, E., 2012).

Figure 24. Government expenditure on health as % of total expenditure on health 2001, and under 5 mortality rate per 1000.

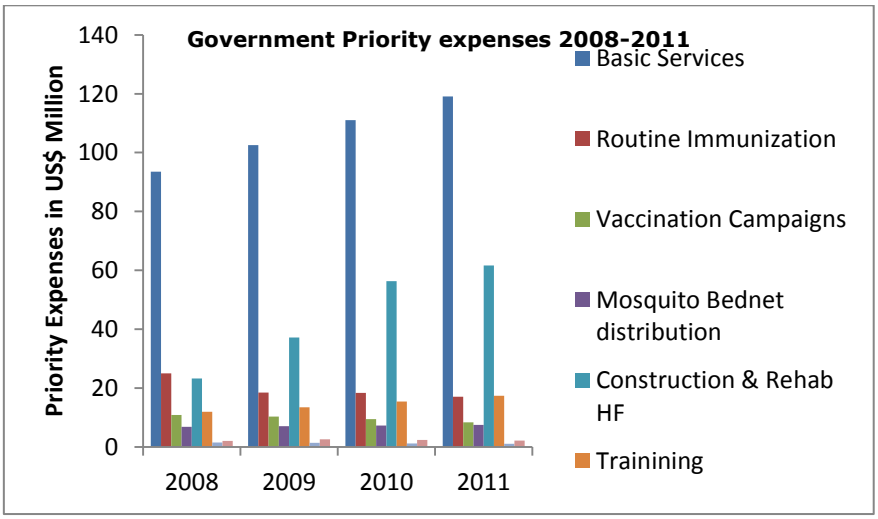


Source: WHO 2004.

3.4.2.3 Other allocations

Basing on Table 1, cost of Health priorities, the government priority is in provision of Basic services together with Construction and rehabilitation of health facilities, that's why they received more funding. Other areas in the health system like development of human resources, development of Health Management Information system are given less attention (See Fig 20)

Fugure 25 Government priority expenditures 2008-2011



4 Chapter 4: Discussion

Between 1983 to 2005, before the CPA was signed, donors under the Operation Lifeline Sudan did have coordinated operation. But then later, many policies and guiding principles were reviewed and new ones formulated; for example, the South Sudan Aid Strategy (2006-2011); South Sudan Expenditures priority and needs (2008-2011) and the current Health Sector Development plan. All these clearly outlined the policies on Aid effectiveness(alignment to local priorities). The challenges now are weak institutional capacity and weak coordination framework with these multiple donors.

Challenges in the principles of alignment and harmonization

Donors have recently demonstrated a willingness and commitment to align their development assistance with South Sudan's national priorities. The remaining challenge is that the donors cannot rely on the country's national systems and procedures, including procurement and public financial management. These administrative systems are weak and the capacity to manage then is limited. More so, reconciling alignment with the country's choices, especially with the global vertical Programs is challenging.

South Sudan donors in the health system are providing "Basic Services", through humanitarian aid. This also proves a challenge to alignment because of emergency responses. Most financial disbursements for emergency are sometimes disbursed off-budget or not through the pooled mechanism.

Clear policies and guiding principles (international and national levels) exist, on how to manage aid effectiveness on the part of the donor and the recipient country. As stated earlier, fear and slow reliance by donors to use South Sudan's administrative systems for reasons of fiscal indiscipline (corruption) remain as the main hindrances to alignment. It would be important for the government of South Sudan to strengthen its existing framework, and for the donors to endorse the use of the country's systems like the Financial Management system, procurement system and audit system.

Many Countries in Africa are moving away from project supported Aid to Sector wide-Approaches (SWAPs) and Budget supported Aid (OECD-DAC, 2005). Approximately 50% funds were aligned with expressed priorities in 2011, as directed by the GoSS expenditure priorities guidelines 2008-2011 (See Fig 23 pg:33) showing facility construction and training with the smallest share. It would be useful for a practical co-ordination mechanism to be in place and move towards Budget support and SWAPs. Through this, a uniform framework towards national and International NGOs regulation and supervision would be achieved. Vertical Programs have been cited for poor alignment; being part of

the DAC working party on aid effectiveness, therefore, the "three Ones principle" would help (GAVI & GFATM) incorporate their funds through SWAPS. A more remarkable move would be for the Government of South Sudan to incorporate the budget planning process to the local levels needs, so as to achieve the principles of alignment and harmonization.

Are we achieving Geographical equity and resource allocation?

Evidence shows that there is an relationship between government total expenditure and DAH on health (excluding privately funded cost of treatments by the population) and health outcomes (infant mortality rate etc.). Donors in South Sudan are yet to achieve geographical Equity and come up with more practical formulas for resource allocation.

Due to the weakness of the existing co-ordination framework among donors, it is difficult to track the activities of the multiple donors, with different interests, working in different regions. This has greatly compromised the equitable distribution of resources across the country, and regional imbalance, hence some remote parts of South Sudan still remain underserved.

The implementing agents under the pooled funds defined their own criteria for resource allocation and Program interventions. The focus is on "high priority states" and "high risk underserved communities and in areas where there are high numbers of IDP's, returnees and high levels of food insecurity. The health interventions focus mostly on factors affecting health (determinants of health) like: improving access to safe water and sanitation facilities; improving access to enhanced quality of education and alternative learning opportunities; and Malnutrition emergency responses.

Due to the above criteria for resource allocation, health Programmes and NGO work concentrations is seen (Annex 4&5) mostly in the greater Bahr-el-Ghazal regions (Northern & Western Bahr ghazal, Warrap, Unity, Jonglei and Lakes), as compared to the Equatorial regions (Central, Eastern & Western regions).

The duration of most funding are short term, this can have an impact on the delivery of services and cause further geographical disparities in resource allocation and sustainability. Government and the donors should find a more workable practical formula for resource allocation as is the case in Zambia.[8]

Shortcomings of the government Health expenditure

South Sudan's dependence on oil (more than 97% of state revenues derived from oil) will result in a less diverse economy and reliance on imports. The country's economy is therefore vulnerable to external shocks in the volatile oil markets. Secondly reliance on oil is undermining effective institutional tax mechanisms, that would otherwise lead to the generation of additional source of

[8] Apart from population density, disease burden Zambia looked at other variables like transport cost and staff incentives in hard-to reach areas.

government revenues. The government health expenditure as a percentage of the total expenditure is low (4.7% below the 15% target set by the AU heads of state in the 2001 with the Abuja declaration (MoFEP 2011)).

The decentralized nature of flow of funds to states as prescribed by Interim Constitution has potential problems; not different from other Federal countries like Nigeria. The allocation methodology allows SMoH's to focus on their local priorities by increasing the decision-space, thus undermining FMoH's ability to coordinate national health policies.

There are instances of duplication of initiatives and inefficient use of resources. The government sometimes adjusts its own spending to off-set donor funding (Fungibility). Transferring funds to unintended purposes, as is the case with the block grants. (Melisa, M & Anna, V 2011) argued that for every US$1 of DAH to government, the government reduced health expenditures by US$0.43-1.14. To fix this shortage for the government could slowly pilot an introduction of user-fees, especially in the urban areas and to establish the National Health Insurance.

4.1 Study Limitations

a) Information on health service provision was hard to get. Actual costs vary considerably when looking at geographical access (some places have no roads one experienced transportation difficulties; some places have no structures at all, so need lots of building, some places don't have HR so it is difficult to conclude if true equity can be achieved.)
b) Financial data at the start of OLS from 1989 to 2005 was not used in the study and it was difficult to obtain information for early 2005 because most NGOs and FBOs (Donors) operations were uncoordinated.
c) Obtaining disintegrated data on funds disbursed by Sudan to South Sudan during the interim period/unity government especially when MDTF was under one umbrella i.e. MDTF Sudan, was challenging.
d) Obtaining financial expenditures by various NGOs and FBOs they privately committed on health outside the pooled mechanism, was difficult.
e) Information on actual expenditures by implementing agencies in different activities and zones was difficult to get. NGOs generally do not make country-specific expenditures publicly available. That limited the researchers' ability to analyze the distribution of DAH and measure its impact.

5 Chapter 5: Conclusions and Recommendations

Conclusions.

This Thesis concludes that:

(i) A level playing ground in health service deliverance has not been achieved, given the context, content, and process under which DAH has operated; and all actors involved in directing DAH to South Sudan. There has been a fluctuating trend of flow of DAH to South Sudan, and the funds have been handled by array of actors with different interests, whose interest are in different health interventions and working in particular geographical areas.
(ii) The government of South Sudan has relied exclusively on oil revenues to fund health care. Poor tax collection and administration system and less support from the public-private-partners (PPPs), has prevented the flow of other revenue sources.
(iii) The country, since the signing of the CPA in 2005, has been formulating policies and reviewing them. The Donor community likewise has been pooling funds to support the struggling health system and continuously disbursed emergency funds to respond to the growing humanitarian needs.
(iv) South Sudan's on-going reconstruction process has achieved to some extent the creation of key health building blocks which will enable donors to follow commitments made in the framework of the international initiatives (Paris declaration, Accra Agenda etc). These building blocks include the recent enactment of the South Sudan Health Sector Development Plan (HSDP), South Sudan Development Plan (SSDP) and improved governance.
(v) To achieve equitable distribution of resources and aligning to local priorities The challenge for DAH will now be to permanently sustain standards reached, by building capacity at the national, regional and community levels, and to give trust to donors, and having a zero-tolerance to corruption, which is threatening to undermine the reconstruction process toward development aid (sustainability).
(vi) Lastly, RSS government should strengthen and integrate civil society and the private sector in planning and coordination.

Recommendations:

1. Aligning and harmonizing DAH with Country priorities

The "Principles for Good International Engagement in Fragile state" are being implemented in South Sudan. Donors' efforts of harmonization and alignment with the country's new HSDP and the overall development plan (SSDP) are

paramount in service delivery, resource allocation (Equity) and poverty reduction.

Therefore it is recommended that,

(a) Donors should:

- *Provide capacity building support*. This will enhance South Sudan's ability to formulate suitable policies, establish and maintain effective institutions, and acquire and use the human skills they need. Capacity building can improve the country's systems such as financial management and procurement.
- Increase their funding on technical cooperation, so as to build capacity. Through this, government staff will be able to acquire technical support to manage finance at the central MoH, State and county especial in costing the current HSDP operational plans.

- *Develop health financing research teams*. This is essential for the MoH so as to get information on areas of health financing gaps and priorities. Studies such as the National Health Accounts (NHA), should be considered to assess the actual expenditures on health by source. Public Expenditure Review (PER) in health and studies on health facility survey to assess various aspects of health care delivery should be considered too. These studies will help the development of health financing policies and provide information on budget planning and execution.
- *Establish better approaches to provision of DAH*. Project support still remains the most dominant instrument for Aid delivery in South Sudan. The challenge is whether it's done in "good practice" principle or not. Secondly whether it's difficult to align with sector Programmes and Mid-term expenditure Frameworks (MTEF).

(b) The government of South Sudan should:

Move towards Sector-Wide Approaches (SWAPs) and Budget support.

Through these new financial instruments, South Sudan can improve on its challenge of "Verticalization". The global initiatives and alliances (GFATM & GAVI) have, since 2008, been instrumental in the country, but the fear that they are creating a separate health system "Silos" as they concentrateon specific diseases and activities. Moving to Budget means that donors can use the country systems of finance.

- *Progress to use and ability to assess country systems.* The country systems like Public Finance Management (Budget formulation, Budget execution, Accounting & reporting, Accountability and Audit) and Procurement. There is need for the donors to provide capacity building and also assess these system for compliance. These systems are currently

not in place or are very weak. For example a joint donor-government procurement coordination system can be established and strengthening the current BSWGs that was established since 2006.

- *Avoid excessive donor fragmentation at country and sector level.* South Sudan has already existing government-led Aid coordination and consultative groups. These groups include the Inter-Ministerial Appraisal committee (IMAC), Goss Door Forum, IDCF, G6, JDO etc, but the challenge for some of these groups is limited capacity and generally lack of inclusion of the lower levels of government in aid coordination and practical poor coordination mechanism. Need to involve SMoH and CHDs in the coordination process and build capacity.

2. Establishing sound micro-economic policies for domestic resource mobilization.

Due to Aid unpredictability, donors have been meeting most the needs gap. It's advisable the government of South Sudan raises more domestic funds through taxation so as not to depend on the oil revenues alone. Sound legal frameworks should be established to collect, administer and account for tax revenues.

3. Community financing arrangements.

The community financing arrangements can be achieved by slowly piloting and introducing Community Based Health Insurance (CBHI) and educating the population about CBHI. As noted in my findings, South Sudan does not have a national insurance scheme, and only a few government civil servants receive the benefits. To avert the over dependency on donors' unpredictable aid flows and the high cost expenditures on private and out-of pocket spending, CBHI is a recommendable alternative. Generally speaking these schemes improve cost-recovery. Tanzania among other Sub-Saharan countries has successfully piloted most of these community insurance schemes (OECD-DAC 2005).

4. Strengthen and integrate civil society and private sector.

Government of South Sudan should strengthen and integrate the civil society and the private sector as the main beneficiaries of aid and key development, and all stake holders should have a clear understanding of their roles and responsibilities, under a practical coordination frame work among all actors.

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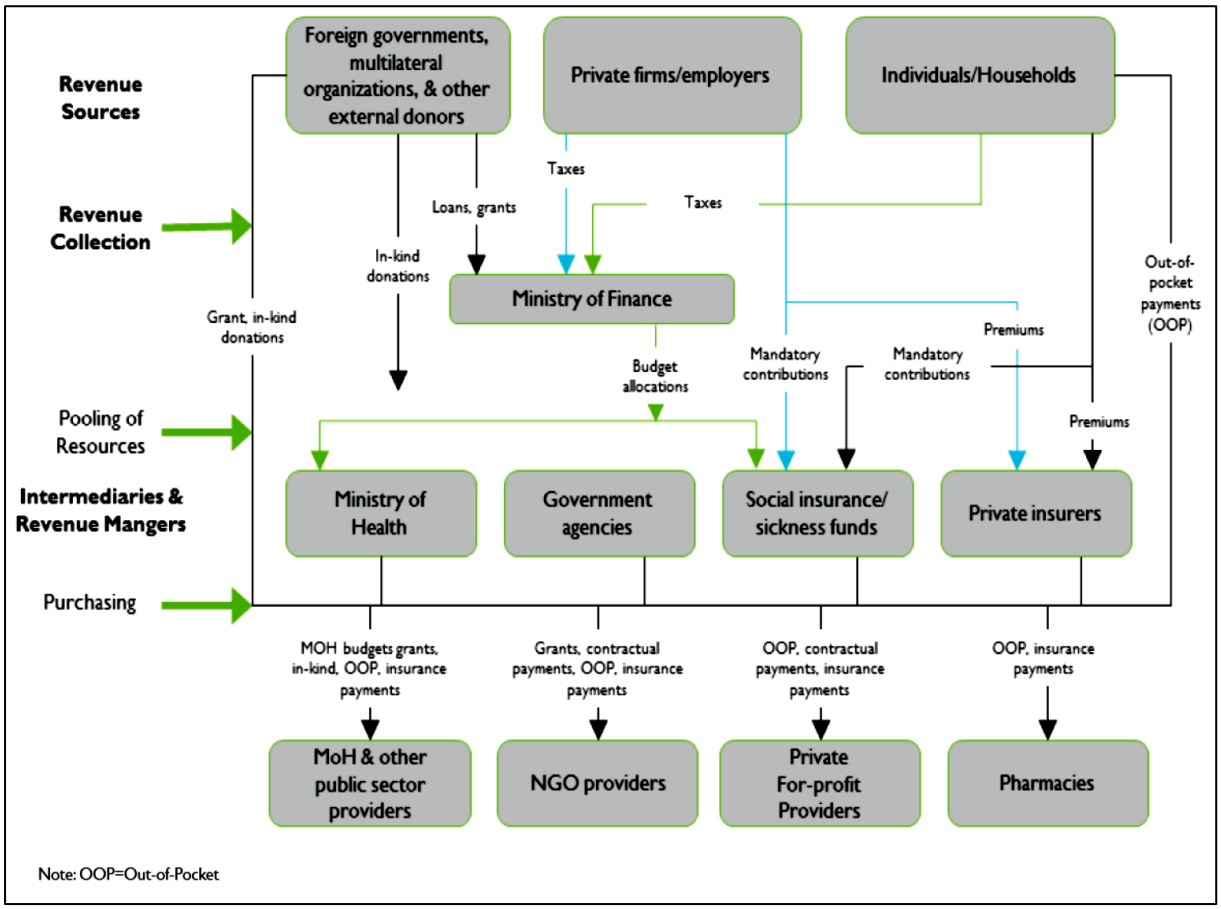
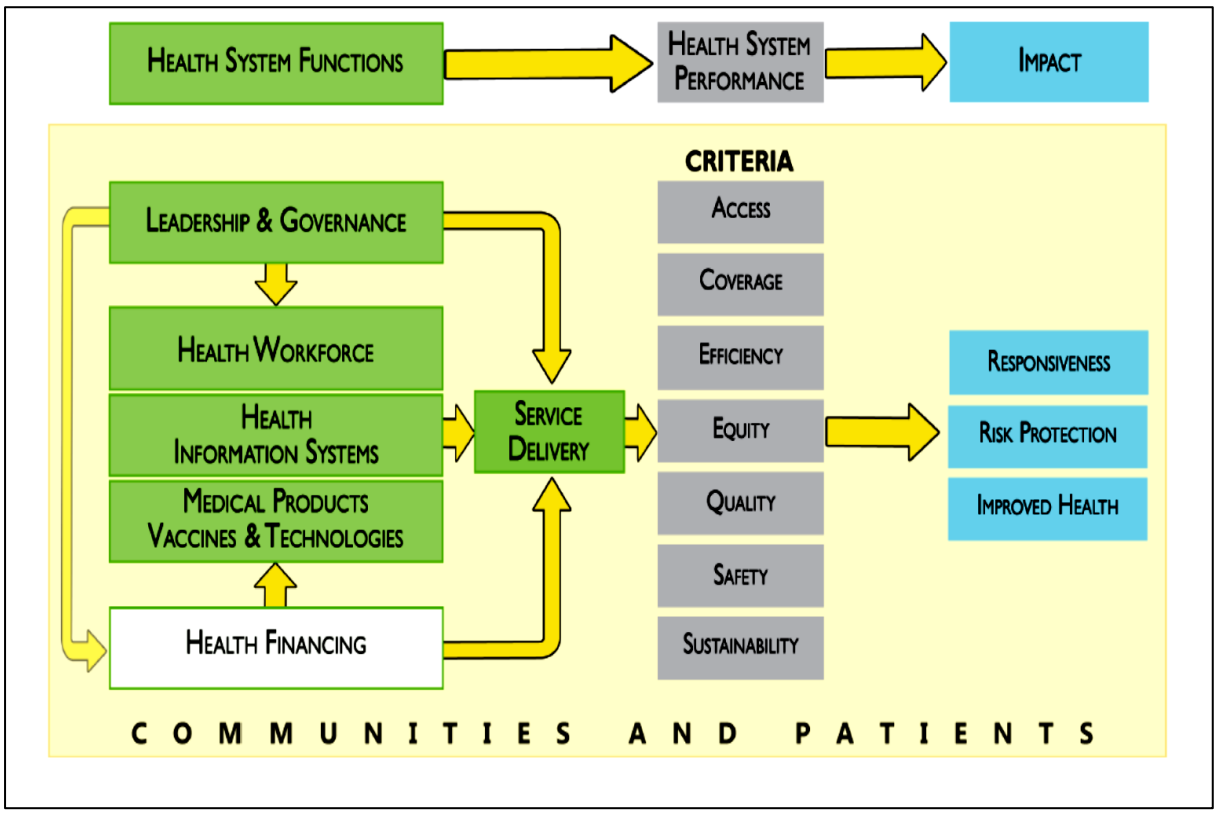
Annexes

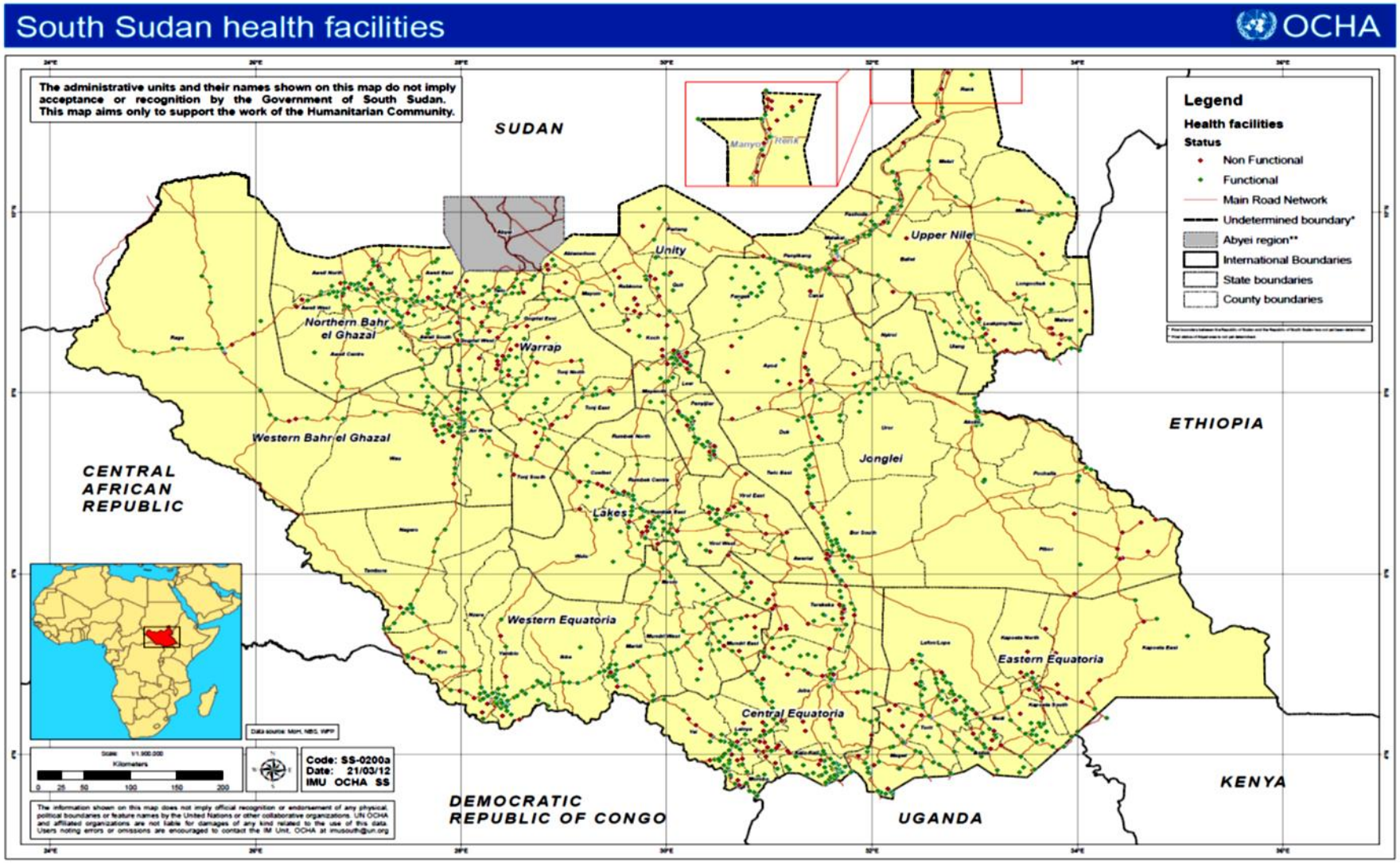
Annex 1. General Health Financing flow.



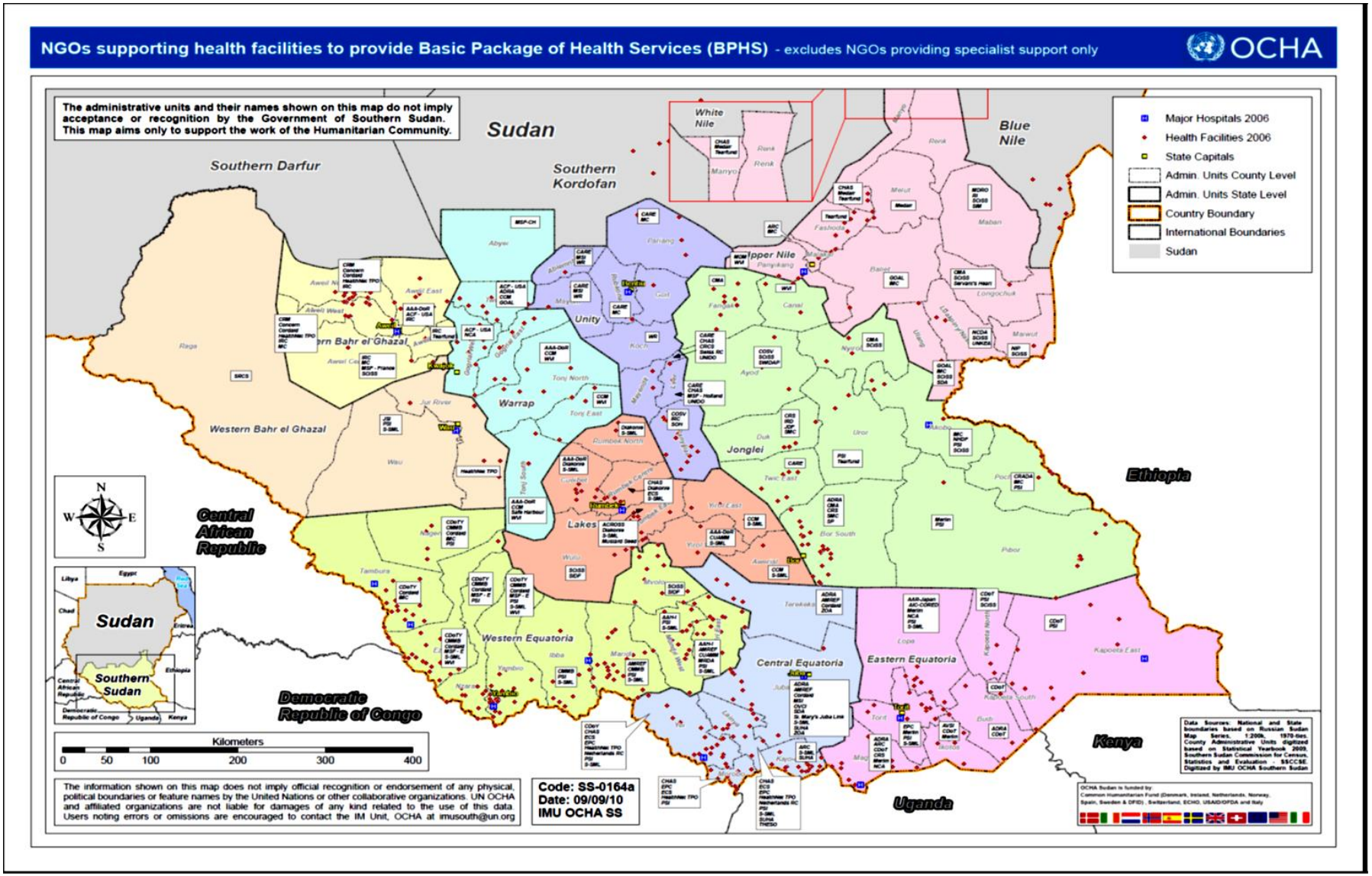
Annex 2. Interaction of the Health building block



Annex 3. South Sudan Health facilities distribution by region 2012



Annex. 4 Distribution of NGOs for the provision of Basic Health Services package 2006



Annex 5. Health Cluster partners 2012