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# HEALTH IN FRAGILE STATES

## COUNTRY CASE STUDY: SOUTHERN SUDAN

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## **Executive Summary**

Decades of rebellion against the internationally recognized government in Khartoum have prevented Southern Sudan from developing even the most basic infrastructure. To this day, there are few roads, telecommunications options, or even buildings. The Comprehensive Peace Agreement (CPA), signed in January 2005, provides some hope for the future, but on many fronts the present condition of the new country remains quite fragile. Perhaps one of the biggest obstacles to development in Southern Sudan is the absolute penury of skilled professionals in the social sectors. As a result, literacy stands at 24 percent (female literacy at 18%), and health parameters are among the worst in the world. In fact, there are only 3,600 primary health care workers, 197 clinical officers, 669 nurses, and 36 doctors for a population of about 7 million.

The risk of renewed conflict is great and is currently the principle driver of Southern Sudan's fragility. The peace accords and the political process through which they could have been solidified were dealt a serious blow by the untimely death of John Garang, the rebel leader who accepted a post in the Khartoum-based Sudanese Government of National Unity (which, along with the Juba-headquartered Government of South Sudan [GOSS], represent the country's two basic governments) as part of the cessation of armed hostilities. Garang's followers appear to be unable to match his charisma, his successful diplomatic engagement, and even perhaps his ability to maintain peace among the sometimes-fractious groups that vie for supremacy in the complicated world of Southern Sudanese politics.

All this being said, Southern Sudan does have one major positive feature: it is potentially rich. Under the CPA, the GOSS will receive half of the revenues derived from its oil (with the rest going to the North). If this money is indeed made available, (and, by all accounts, it will be), it may be sufficient to provide a solid basis for stabilization-based programming. For example, the GOSS has been able to promise a 2:1 match of every dollar it receives from the new World Bank-managed Multi-donor Trust Fund, which has planned to put \$125 million into the fledgling health sector.

Sudan's oil is of great importance on the international scene. China, for example, obtains 10 percent of its oil from Sudan and, as a result, has a stake in maintaining political stability there. Yet, 98 percent of the oil is in GOSS-controlled territory, and a scheduled vote for independence in 2011 looms as another potential area of fragility unless the North can be assured that the terms of the CPA will prevail. The asymmetric arrangement between the Government of National Unity and the GOSS may also be a source of instability unless both parties can deftly manage it.

### **The Health Sector**

Health services in Southern Sudan are provided largely by a patchwork of international and local non-governmental organizations (NGOs), both secular and faith-based. Health coverage is estimated to be around 25 percent of the population, and there is little uniformity in the level, type, or quality of services. Existing health facilities are generally few, inadequately equipped, and have limited operational capacity. In 2003, there were 551 basic primary health care (PHC) units, 103 more comprehensive PHC centers, and 19 hospitals in the provincial capitals and garrison towns. The common contributors to childhood mortality, including malaria, dominate the disease profile, but tropical diseases such as trypanosomiasis, lymphatic filariasis, and even dracunculiasis are the subjects of vertical programs implemented by international agencies and NGOs.

Building from this extreme minimum, government authorities are now seeking to build (note: not to rebuild) a system from the ground up. With help from the World Health Organization, a Basic Package of Health Services (BPHS) was developed that can provide a road map around which the donors (even those not participating in the MDTF)

can harmonize their efforts. Still, a quasi-total lack of human resources is likely to considerably slow the effort unless innovative solutions for health service delivery can be found. It must be said that human resources are so lacking that it has been difficult even to staff a central administration that might be able, for example, to oversee and manage service delivery quality by private organizations. Again, although money may not be a problem, absorptive capacity is a limiting factor in Southern Sudan, more so than in most other fragile states.

Finally, a word is in order regarding the physical and security environment. Even if human resources were in adequate supply, there are no roads or communications. Just bringing in and distributing supplies represents a considerable problem. Although the CPA with the North was signed and is being implemented, insecurity continues to represent a considerable threat, with recent reports that the marauders from the Lord's Resistance Army are wreaking havoc along the few transport lanes that exist in the southern parts of the country, sometimes blocking road access from the major supply point of Lokichoggio, Kenya.

### **International Development Partners**

One obstacle to the development of Southern Sudan is that donors continue to operate in emergency mode. The humanitarian relief arms of the United States Agency for International Development (USAID), Department for International Development (DfID), and the European Community (EC) continue to have large programs and, as has been noted in other countries, the transition from relief to development within these agencies has not always been smooth. Operation Lifeline Sudan involved more than 40 NGOs and their funding source will need to be ensured. One initiative among all of the projects has been USAID's "Health Transformation Project," the only project directly aimed at strengthening the government's ability to develop in the health sector. However, while it was supposed to work in twenty counties of the South, it has reached only six. Major obstacles regarding drug procurement, as well as a geographical shift in focus attributed to the implementation of USAID's new Fragile States Strategy, have brought this project close to a standstill, pending further developments. Together with the bilateral donors, the World Bank, Global Fund, and Global Alliance for Vaccines and Immunization (GAVI) all have programs in Sudan.

A Joint Planning Mechanism was created in May 2003 under the guidance of the World Bank, USAID, United Nations (UN) agencies, and the International Monetary Fund (IMF). Under this plan, rehabilitation and transitional recovery needs were assessed, priorities determined, and action plans drawn. Nearly \$2 billion was pledged, including money to rebuild health facilities and services. To date, there has been little progress, due the slow CPA implementation, slow GOSS organization, inadequate human resources, and serious geographical and security constraints. In addition, weather is also a problem—a long rainy season means that programs can only function optimally between September and April. Finally, the lack of infrastructure in Juba, the capital, has impeded development organizations and, indeed, the government, from leaving their offices in Nairobi. Although the physical relocation of the Southern Sudan health community to Juba is now well underway, it is far from complete.

## Lessons Learned and Recommendations

Achieving substantial development of South Sudan's health system will require patience, persistence, and attention to drivers of fragility that, on the surface, may not seem to be directly related to health. The lack of infrastructure and human resources is as crippling as that of any country in the world. The asymmetry of the current political arrangement, with a Government of South Sudan "embedded" within a Government of National Unity, may prove problematic. Rich in oil deposits, Southern Sudan will have to ensure that the revenues it derives from its natural resources are used efficiently and effectively to both maintain its full independence and provide visible social services to its population, including health and education, as well as jobs and other income-generating opportunities. Although its government is not "transitional" in the same sense as that of, for example, the Democratic Republic of Congo, current investments must bear in mind that a referendum for independence will be held in most areas of Southern Sudan within five years. The consequences of that vote will undoubtedly determine whether or not donor investments will pay off.

As with other fragile states, the key to health system development will be to develop short-term programming in keeping with a clearly articulated long-term vision. The long-term must include a plan for developing a human resource base for both the management and delivery of health services, attention to communications, procurement, health care financing, and other fundamental management processes. The development of a Basic Package of Health Services is a good start.

Specific short-term recommendations include:

- Provide technical assistance, especially in management, within the fledgling Ministry of Health in Juba and in provincial offices
- Establish an efficient and affordable drug procurement system
- Construct (rehabilitate) health facilities in accordance with a donor-government prioritization scheme
- Ensure that these visible elements of the "peace dividend" are prominent in areas of greatest fragility—it may be more important for the government to reduce the risk of renewed conflict before emphasizing an equal distribution of social services

## Abbreviations

AMREF	African Medical and Research Foundation
ASAP	Consolidated Appeal for the Sudan Assistance Plan
BPHS	Basic Package of Health Services
CHDs	county health departments
CHF	Common Humanitarian Fund
CHW	community health worker
CPA	Comprehensive Peace Agreement
DAC	Development Assistance Committee
DfID	Department for International Development
DOE	US Department of Energy
EC	European Community
ECHO	European Community Humanitarian Office
GAVI	Global Alliance for Vaccines and Immunization
GNI	gross national income
GoS	Government of National Unity
GOSS	Government of South Sudan
HIPC	Heavily Indebted Poor Countries
ICG	International Crisis Group
IDA	International Development Association
IGAD	InterGovernmental Authority on Development
IMF	International Monetary Fund
INGOs	International non-governmental organizations
IRIN	Integrated Regional Information Network
JAM	Joint Assessment Mission
JPM	Joint Planning Mechanism
M&E	monitoring and evaluation
MDTF	Multi-Donor Trust Funds
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGOs	Non-governmental organizations
NSCSE	New Sudan Centre for Statistics and Evaluation
OCHA	Office for the Coordination of Humanitarian Affairs (United Nations)
OCHR	Office of Civilian Human Resources
ODI	Overseas Development Institute
OLS	Operation Lifeline Sudan

PHC	primary health care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PINR	Power and Interest News Report
QIPs	quick impact projects
SHTP	Sudan Health Transformation Project
SOH	Secretariat of Health
SPLM/SPLA	Sudan Peoples Liberation Movement/Army
SRRA	Sudan Relief and Rehabilitation Association
SSDF	South Sudan Defense Force
TRM	transitional results matrix
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VHVs	village health volunteers
WHO	World Health Organization

All dollars are in U.S. dollars unless otherwise noted.

# 1 Analysis of Framework Conditions

## 1.1 Nature of fragility

The chronic conflict in southern Sudan is primarily the result of the North–South division of Sudan, which began in the early 1820s with the imposition of Turco–Egyptian rule that vastly increased the scale of official slave-raiding from Muslim areas against non-Muslim areas. The combination of political and economic structures resulted in the equating of “black” with “slave” in the minds of northerners. This pattern was reinforced following the Anglo-Egyptian reconquest of the Sudan of the Mahdist rebellion in the 1880s. The British moved to negotiate compromises with competitors there and promoted a non-Mahdist Muslim orthodoxy. However, the South remained peripheral, partly because the British did not have to negotiate with competitors and also due to its physical distance from the political center of Khartoum. The paucity of Anglo–Egyptian governance in the South led to the continuation of coercive policies, such as forced recruitment into the army, which resulted into a prolonged period of pacification through the 1920s. In 1930, the British Civil Secretary declared a Southern Policy in which Southern Sudan would be developed along African, rather than Arab, lines and aligned with the fates of British East Africa rather than the Middle East. In this later period, the Anglo–Egyptian government instituted a board of *ulama* to define Muslim orthodoxy in an attempt to control Islamic interpretations that might pose a threat to their rule in the North, while in the South, interaction of different groups was considered dangerous and attempts were made to ensure cultural purity. The net result was an increasingly homogenized Islamic culture in the North and a religiously heterogeneous South.

Southern fears of Northern domination and colonization led to a mutiny in 1955 that largely subsided until the imposition of Muslim education in the South and other coercion resulted in an insurgency in 1960–62, as northern parties came to the view that Sudan should be an Islamic state. The rebellion was highly disorganized until the coalescing of the Southern Sudan Liberation Movement created a credible partner for the 1972 peace agreements ending the conflict. However, the agreement failed to resolve differing perceptions of autonomy and federalism. This was aggravated when Sudan was unable to pay its loans in 1977–78, resulting in dependence upon the U.S. (Sudan was the largest recipient of U.S. foreign aid in sub-Saharan Africa and seen as a key African ally in the Cold War). The economic crisis in turn resulted in increased tension over the newly discovered oil fields located mainly in the South.

Despite the 1972 peace agreement in Addis Ababa, a small number of rebels had remained in hideouts in Ethiopia. As it became clear that the Khartoum government of Nimeiry was abrogating the terms of the agreement, support for these rebels grew. The mutiny of a battalion in January 1983 led to the movement of Col. John Garang to the Ethiopian rebel stronghold, where he started the Sudan Peoples Liberation Movement/Army (SPLA), with a manifesto outlining specific grievances in the context of overall under and unequal development.

The SPLA drew the lesson from the first rebellion that internal cohesion was vital and devoted much of its energy towards opposing factions in the South. This allowed it to make substantial military gains that contributed to a coup overthrowing Nimeiry in April 1985. Garang refrained from the subsequent elections, pointing out that the SPLA’s grievances were institutional and not personal. Nevertheless, the SPLA lost its initial focus on revolution of the existing state, rather than separatism for the South, which allowed it to gain adherents in the North. Its failure to convince northern opposition groups that their objectives and those of the SPLA were the same, as well as convince the South that unity within a “New Sudan” would be better than an independent Southern Sudan, contributed to the bloody continuation of the war. Through the

latter half of the 1980s, the SPLA continued to expand and consolidate its area of control, even moving the war into areas beyond the South, such as Blue Nile, Darfur, and the Nuba Mountains. This resulted in the signing of an accord between the SPLA and the DUP party in November 1988 that came close to ending the war before a coup by Muslim officers backed by the National Islamic Front cancelled the deal. The SPLA continued their expansion, including attacking the Khartoum-backed Ethiopian rebel groups, until the overthrow of Ethiopian President Mengistu in May 1991 set it back. This perceived weakness, and authoritarianism of Garang, led to a split in the SPLA, with several commanders based in Nasir declaring his overthrow. This resulted in a series of military reversals that were rolled back only in 1995–96, when Khartoum's external relations were suffering due to alarm over their expansionist Islamic ideology. This followed the disintegration of the Nasir-faction, known as the SPLA-United, after it had seized much of Equatoria, leading to what has been referred to a "civil war" within the Nuer ethnic group (Johnson 2003). The war, the death toll for which varies from 1.3 million to 3 million, came to an end with the signing of a Comprehensive Peace Agreement in January 2005, which the government agreed to under intense foreign pressure as other regions in the country appeared to head towards conflict. However, the peace process was shaken when Garang died in a helicopter crash in July 2005. As the peace process was highly personalized around Garang, who had both ruthlessly suppressed southern dissent and personalized power around himself, as well as gaining a degree of trust by many northerners for his consistent pushing for a fair union, rather than secession, it remains unclear if Salva Kiir Mayardit is adequate to the task. Both the government's commitment to the peace process and the cohesiveness of the SPLM have been questioned.

## **1.2 Socio-demographic and cultural context**

The population of Southern Sudan is disputed both due to the lack of credible census data and the return of hundreds of thousands of refugees since the signing of the January 2005 CPA. The Multiple Indicator Cluster Survey (MICS) states the population at 5.06 million (MICS, 2000). The New Sudan Centre for Statistics and Evaluation (NSCSE) reinterpreted the data to be 6.6 million and estimated the population to be about 7.5 million in 2003, with further growth to 12 million by 2010, due to returnees and a population growth of about 3 percent per annum (NSCSE & UNICEF, 2004, 27). The MICS conducted in 1999 reported that 56 percent of the population is below 17 years of age, 56 percent of the population is in Bahr el Ghazel and Lakes, 32 percent in Equatoria, and the remainder in Upper Nile and Jonglei; there are twice as many women as men above 17 years of age, but 20 percent fewer girls than boys under five, and 12 percent less girls between ages 6 and 17 (MICS, 2000). NSCSE argues that these numbers are due to missing data, in particular 500,000 males over 18 years of age who are thought to be uncounted as they are in the rebel army, nomadic, or migratory, or killed in the fighting. The male-female ratio is almost 50/50 with 21 percent of the population under the age of five and a total fertility rate of 6.7 percent. As of 2006, the 13–17 year old and 8–11 year old age cohorts are low, due to famines in 1992 and 1998 (NSCSE & UNICEF, 2004, 34). The Southern Sudan inhabitants are from four main ethnic groups: Nilotics, Nilo-Hamites, Bantu, and Sudanic (Salinas & D'Silva, 1999, 4). The vast majority of the population works in the agricultural sector—divided between the pastoralists and agriculturalists. Equatoria ethnic groups tend to be settled agriculturalists, compared to the pastoralists such as the Dinka and Nuer. The Dinka are the largest group in the South, and the Dinka language is the second most widely spoken after Arabic.

### 1.3 Economic context

Southern Sudan contains two major resources: oil and water. Many of the Nile tributaries originate in or pass through Southern Sudan. Through the twentieth century, there has been a long-standing proposal to divert the waters that create a large swamp in Jonglei to raise the water level of the Nile for use by the downstream communities in the North and Egypt. The Egyptian view that draining of Jonglei is required for their long-term water needs has led to their consistent opposition to southern secession.

The South's major asset is oil. Sudan has proven oil reserves of 563 million barrels of oil, much of it in central and south-central regions (US Department of Energy [DOE], March 2005). Estimated total reserves are 2 billion, much of it in the Upper Nile and Jonglei Provinces (Johnson 2003, 45). Since the completion of an oil export pipeline to Port Sudan in July 1999, oil production has steadily risen from 270,000 barrels per day in 2003, to an estimated 500,000 barrels per day in 2005. The oil fields have been the focus of much fighting, and the pipeline was the target of a failed raid by eastern forces in October 2004. Sudan's oil infrastructure has received significant investment from foreign investors, notably China. According to the Comprehensive Peace Agreement (CPA), oil revenues should be split between North and South 50/50 (DOE 2005). Sudan's oil comes almost completely from wells located in the southern third of Sudan (Human Rights Watch, 2003). In March 2006, the first funds began arriving in GOSS- controlled accounts.

Macroeconomic indicators are as disputed as the population estimates. "The Sudan Health Status Report" of August 2003 refuses to guess due to "the complete absence of national income account statistics," while the NSCIE estimate of per capita gross national income (GNI) is \$90 per year (less than one-fourth that of the rest of Sudan), with the proportion of the population living on less than a dollar a day is around 90 percent. The Southern Sudanese have extremely bad access to primary education, with a regional net enrollment of about 22 percent and the ratio of female-to-male primary school enrollment at four-to-one (UNICEF, 2006). Primary school completion is the lowest worldwide at 2 percent, with female primary completion lagging behind only Afghanistan under the Taliban at 0.8 percent. These numbers mean that 500 girls and 2,000 boys finish primary school every year. These education numbers result in an adult literacy rate of 24 percent (second to Niger), adult female literacy rate of 12 percent, and a youth literacy rate of 31 percent (NSCSE & UNICEF, 2004). However, significant numbers of Sudanese outside the country have access to education. United Nations High Commissioner for Refugees (UNHCR) notes that 65,000 Sudanese refugee children in Uganda have access to free primary education, a number that does not include the self-settled unregistered refugee population (Duncan, 2004).

Although most economic activity is agricultural, only two percent of the land suitable for agricultural production was under cultivation in studies prior to the war. The conflict situation has reduced this percentage to below one percent (World Bank 2003b, 11). Financial institutions collapsed in the late 1980s, and Southern Sudan reverted to a barter system in 1994. The situation improved so that by 2003, over 75 percent of the economy was monetized (ibid, 17).

The estimated inflow of humanitarian assistance to Southern Sudan in 2001 was \$215 million or about \$31 per capita. However, the World Bank argued that as this amount does not arrive as cash injections, but as relief supplies and relief workers, it has a distortionary effect on the economy, depressing demand for local products, and distorting the price structure (World Bank, 2003b, 15)

#### **1.4 Quality of governance, institutions, and policies (including the role of local authorities)**

Integrated Regional Information Network (IRIN) describes the situation in Southern Sudan at the end of 2005 as “a region with almost nothing in terms of basic services, roads, telecommunications and building infrastructure. Government institutions in the southern capital of Juba were extremely weak, and at the state and county level almost nonexistent” (IRIN, January 9, 2006). Following the death of Vice President John Garang, the SPLM appeared to lack a strategy for post-conflict Southern Sudan, resulting in ambiguous political initiatives (IRIN, November 15, 2005).

The dominance of the northern riverine states in the creation of unequal development was addressed in the previous sections. Within the South, governance and institution building is hampered by the lack of a strong central authority and the presence of numerous competing armed groups. John Garang’s sudden death was a clear blow to the South. Garang had personalized and centralized power around himself both through an authoritarian crushing of opponents and through the status afforded him as the foremost rebel leader, rather than transfer loyalties to institutions (International Crisis Group [ICG], August 9, 2005, 3–4). Garang was unique in that he was perceived to be for a united “New Sudan” despite widespread calls for independence among Southerners, and thus had the credibility to negotiate directly with government figures and form alliances with northern opposition figures, who strenuously oppose the idea of breaking apart the country. In the words of the International Crisis Group, Garang “transcended the South.” His replacement, Salva Kiir Mayardit, also a Dinka, has less prestige within the SPLA, is seen by the government as soft on the idea of the union, and has less experience at high-level negotiations, which worked against him in negotiations over cabinet positions in which the SPLA lost the key oil portfolio (Wolfe, 2005). Sensitive portfolios were also removed from Southern control by presidential decree after the cabinet was decided, with aviation being taken from the SPLM Minister of Transport. The SPLM had also received only \$60 million in oil revenue in November 2005, about one-tenth of what was expected (IRIN, November 15, 2005). The North’s clear reticence to turn over control of key areas has resulted in a disillusionment of many southerners, who now seem more focused in their desire to secede.

The Government of National Unity came into being on September 20, 2005, and a cabinet for the southern government was appointed in October 2005 (IRIN, November 15, 2005), followed by the signing of a new constitution in early December, a necessary step in the creation of state constitutions, governments, and assemblies (IRIN, December 6, 2005).

The advancement of Mayardit also resulted in the promotion of Riek Machar as Vice President for the South. It is unclear if the rise of Machar, the Nuer who led the Nasir faction in the bloody internecine warfare of the late 1990s and was reconciled with Garang only in 2001, will result in a new cooperation between him and Mayardit, or if it will result in the reappearance of the sometimes-violent tensions between Dinka and Nuer. Machar was the SPLA liaison with the government-allied South Sudan Defense Force (SSDF), but clashes between the SSDF and SPLA in early February 2006, indicate a substantial failure in the timeline, despite a January 2006 deadline for all militia groups to merge into either the SPLA or government Sudan Armed Forces. Former SSDF (now SPLA) Commander Paulino Matip stated that the government military intelligence was encouraging the SSDF to disrupt the CPA (British Broadcasting Corporation [BBC], 2006). Besides this tension, particularly in Upper Nile, the insecurity caused by the Lord’s Resistance Army in regions of South and southeastern Sudan has made logistics difficult (IRIN, February 20, 2006).

## 1.5 Non-state actors

The role of non-state armed actors operating in the South, such as the SSDF and LRA, was discussed above. However, the South's fate is inextricably bound up with the other civil conflicts of Sudan, in particular that of the East by the Beja people of Red Sea and Kassala, and of the West with the Fur. While both conflicts emanate from grievances about the Khartoum government's authoritarianism, both also have an international component—Eritrean support for the Beja Eastern Front (ICG, January 5 2006) and the alignment of non-Arab Darfuri groups, such as the Fur and Zaghawa, towards the Habre regime in Chad (Johnson, 2003, 140). Both groups were excluded from the power-sharing CPA, resulting in an situation in which the SPLM and government are effectively allies in the disenfranchisement of the East and West. In the CPA framework, only 20 percent of the legislative seats are apportioned for the northern opposition, Darfur movements, Eastern Front, and other parties.

As a national movement for a just "New Sudan," the SPLM was in a position to credibly negotiate with these other belligerents, but much less so as a secessionist movement. Both opposition politicians and political activists saw the loss of Garang as a setback, as a potential counterweight to the National Congress Party. In particular, Garang was close to the chairman of the Sudan Liberation Army, the largest rebel group in Darfur, and a supporter of the groups composing the Eastern Front. The loss of a key supporter in Khartoum increases the chances that these groups will use violence as a means to force the government to the bargaining table.

## 1.6 Summary

Sudan is a heterogeneous country with a clear ethnic and religious division between mainly Muslim/Arabic North and a mainly Christian Hamitic South, and has known wars since the Sudanese independence in the 1950s.

Southern Sudan is a region with almost nothing in terms of basic services, roads, telecommunications, and building infrastructure. Government institutions in the southern capital of Juba are extremely weak and at the state and county level almost nonexistent. Education and literacy rates are at the world's lowest levels.

Under the charismatic John Garang, a Comprehensive Peace Agreement was signed in January 2005, which the Sudanese government agreed to under intense foreign pressure, as other regions in the country appeared to head towards conflict.

When John Garang died in a helicopter crash in July 2005, the peace process was shaken, as it was highly personalized around Garang, who had both ruthlessly suppressed southern dissent and personalized power around himself, as well as gaining a degree of trust by many northerners for his consistent pushing for a "fair" union, rather than secession.

His successor, Salva Kiir Mayardit, has less prestige within the SPLA, is seen by the government as soft on the idea of the union, and has less experience at high-level negotiations. As a result, fissions are emerging in the southern alliance, and the SPLA has lost key ministry portfolios.

The still-unresolved Darfur intensifying conflict is putting increased stress on the North–South Comprehensive Peace Agreement.

The economic picture is potentially good, with a high per capita income through the oil revenues of \$600 million or roughly \$100 per inhabitant a year. According to the CPA, the oil revenues are to be split equally between North and South. Of the 2003 production, 98 percent came from wells located in Southern Sudan. At the time of this report, the first installment reportedly materialized into the GOSS accounts. The GOSS intends to use these funds to match \$2 for every dollar spend by the Multi-Donor Trust Funds (MDTF) managed in cooperation with the World Bank. This could mean an important extra resource for the longer-term development strategy for Southern Sudan.

## **2 The Health Sector**

### **2.1 System organization and infrastructure**

With little in the way of a pre-existing functional health system, health authorities are seeking to build a system largely from scratch. A central Ministry of Health will be charged with policy setting, overall planning, coordination and oversight of the sector, while responsibility for health service delivery will be largely decentralized to 10 state ministries of health and county health departments (CHDs). One of the first steps by WHO/Emergency and Humanitarian Assistance has been the development of a proposed Basic Package of Health Services, which outlines five levels of facilities and service provision: community-based health activities, primary health care unit (PHCU), primary health care center (PHCC), county hospital (CH) and county health department (CHD).

Existing health facilities are in poor condition, inadequately equipped and with minimal operational capacity. In 2003 there were 19 hospitals, 103 PHC centers and 551 basic PHC units in SPLM-administered areas. In addition, there are approximately 10 hospitals and 20 health centers in the former garrison towns, about half of which are in Juba. There is considerable geographic inequity in the distribution of infrastructure, with facilities to population ratios highest for Bahr el Ghazal and lowest for Equatoria (SoH [Secretariat of Health], SPLM, 2004). In some rural areas there are about 75,000 people per health center, with as many as 160,000 per health center in Bahr el Ghazal (Joint Assessment Mission [JAM], 2005a) Only a few hospitals are capable of providing adequate referral care; some hospitals are actually disease-specific facilities only (for example, kala-azar or TB treatment). Most rural areas have no access to hospital level services.

The proposed restructuring of health services calls for the development of approximately 800 PHCUs (1 per 15,000 persons), 240 PHCCs (1 per 50,000 persons) and 40 county hospitals (1 per 300,000 persons). These figures attempt to take into account the large expected population increase due to returnees and natural growth in the coming years. The March 2005 UN Joint Assessment Mission needs assessment also specified that new investment in infrastructure should privilege rehabilitation over new construction, focusing on facilities in the most deprived areas and the upgrading of existing hospital structures.

The acute shortage of skilled human resources restricts coverage expansion. Lesser-skilled staff dominate the current health workforce, with an almost total absence of midwives and mid-level personnel. The 2004 SPLM assessment estimated that there were approximately 4,600 trained health personnel in SPLM-administered areas, with over half working in Equatoria. These included some 3,600 PHC workers (nine months' training), 36 doctors, 197 clinical officers, and 669 nurses. These estimates yield a physician-population ratio of just 0.5 per 100,000 persons in rural areas. In addition, there were an estimated 1,500 additional skilled health staff (including 126 doctors and 1,100 nurses) in Juba, Malakal, and Wau. The total baseline skilled workforce is estimated at 2,400 (doctors, clinical officers, nurses, and certified midwives.) A World Health Organization-led inventory of all health staff working in South Sudan was planned for the end of 2005 to inform the Ministry of Health's (MoH's) Human Resources Development Plan. Existing personnel also lack recent training and are in need of refresher courses. Since 1998, African Medical and Research Foundation (AMREF) has operated a clinical officer training facility in Maridi County, Equatoria. AMREF has planned to expand the Maridi Institute into a training center for other health professionals as well, including midwifery and pharmacy technician training, and continuing medical education. WHO and the MoH are

also establishing a new training center in Rumbek; training of midwives and health managers began in late 2005.

The drug supply is highly fragmented and inefficient, with no functioning central purchasing, distribution or regulatory mechanisms in place. In recent years, UNICEF and *Pharmaciens Sans Frontières* have operated the two main procurement systems; options are currently being explored for developing more efficient procurement and distribution systems for the region. Under the MDTF/GOSS Health Sector Umbrella Program, funding has been targeted for the development of a pharmaceutical management, supply, and distribution system and the rehabilitation of central and regional warehouses. The Rapid Impact Emergency Project is currently financing a 10-month supply of drugs to existing health services and supporting the renovation of the central warehouse in Juba. Regular procurement of drugs will be financed under the Umbrella Program starting in the last quarter of 2006.

Essential drug lists and treatment guidelines vary across NGOs and donors. The new Interim Health Policy states that the MoH is responsible for providing essential drug lists for each level of health facility and providing guidelines and training for health workers on how to use drugs rationally. The policy also specifies that no medicine may be donated to the MoH or its implementing partners if it is not on the essential drug list.

## **2.2 Health care providers and service delivery**

Current health services consist of a patchwork of mostly NGO-run humanitarian interventions in rural areas and some limited government health services in major towns. Overall coverage of basic health services is estimated at only 25 percent of the population (JAM, 2005a). Health services in Southern Sudan have been largely financed and run by international non-governmental organizations (INGOs) and local and church-based organizations, with the support of numerous bilateral and multilateral partners.<sup>1</sup> UNICEF and WHO have been instrumental in facilitating coordination, conducting surveillance, and operationalizing specific disease control, nutrition, and immunization programs. Service provision remains highly project-based, focusing on first-level health services and specific communicable disease interventions. The SPLM's 2004 Health Sector Recovery Strategy described a situation in which health services were fragmented both horizontally across some 69 NGOs and vertically, according to disease-control programs.

Under the consistent framework of the Basic Package of Health Services for Southern Sudan, health authorities are seeking to move from inefficient independent projects to a sector approach with the aim of building a single health system. Given the MoH's limited capacity to deliver services in the short-term, it is expected that the BPHS will be implemented by a variety of actors, with NGOs remaining the main service delivery vehicle in the near future. The government will begin contracting-out to implementing partners to provide the defined BPHS in five targeted geographical areas<sup>2</sup> (GOSS, 2006). Over time, the GOSS hopes to shift more towards local NGOs as the main service providers.

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<sup>1</sup> Richer's "Overview of Health Sector in Southern Sudan – 2002" provides a good overview of all the various NGO and UN activities in the health sector, including training programs and facilities (Richer, 2003a; Richer, 2003b).

<sup>2</sup> Contract areas under the Umbrella Program are grouped as follows: 1) Western Bahr el Ghazal, Lakes; 2) Western Equatoria; 3) Central Equatoria, Eastern Equatoria; 4) Upper Nile, Unity, Jonglei; and 5) Northern Bahr el Ghazal, Warrap.

The draft BPHS includes curative, preventative, managerial, and health promotion activities, with specific service profiles defined for community-based activities, PHCUs, PHCCs, county hospitals and CHDs. According to the BPHS, PHCUs will be operated by two health staff (a community health worker [CHW] and a mother and child health worker / midwife) who will provide basic preventative and curative services. PHCCs will be staffed by clinical officers and nurse–midwives and will offer a broader range of services including laboratory diagnostics and 24-hour emergency obstetrical care. County hospitals will serve as the first-line referral hospital for two to three counties, an area of approximately 300,000 persons. The first version of the BPHS is expected to cover the period 2006–08, with a subsequent version developed for the following three years.

The major constraint to increasing the provision of health services in Southern Sudan and expanding coverage is the lack of GOSS capacity, particularly in regards to human resources. To account for this, emphasis has been placed on a gradual rollout of expanded coverage to avoid the “introduction and perpetuation of substandard health services,” leading to low staff morale and under-utilization (WHO. 2005a). At the same time, a Quick Wins strategy (including measles vaccination and insecticide-treated net distribution) targeting populations not yet reached by services was proposed in an effort to achieve immediate results. In the short term, the UN Joint Needs Assessment (March 2005) also suggested that NGOs expand mobile teams to ensure basic service provision for hard-to-reach areas and returnees, and that NGOs be provided with incentives for working in the most difficult areas (JAM, 2005a).

Major externally-driven service delivery initiatives include the USAID-funded Sudan Health Transformation Project (SHTP), a five-year health sector development project aimed at increasing access and utilization of high impact services, increasing local capacity to deliver and manage health services, and improving access to safe water and sanitation. The main implementing partners are JSI and the GOSS. The project used to target 20 counties considered at risk for conflict in Upper Nile State and the transitional areas. Following USAID’s policy shift towards a Fragile States Policy, the funding was shifted from those 20 counties toward the three transitional areas (Blue Nile, Southern Kordofan, and Nuba mountains). It is worth mentioning that these three transitional areas are not historically and technically part of the South and will not get a referendum on their future status in 2011. Some GOSS / SPLM Secretariat of Health (SOH) members have therefore strongly expressed distress at what they felt a moving of USAID funds out of the South.

Outside of urban centers, the for-profit private sector is negligible and is not expected to play a significant service delivery role in the future.

## **2.3 Financing and financial management**

The GOSS has indicated that it will allocate a significant portion of the national budget to the health sector, as much as 10–15 percent of the total budget (GOSS, 2006). However, the amount of planned GOSS spending on health outside of the MDTF/GOSS mechanism is not yet known.

Not including direct government spending, it is estimated that total health spending from international sources and MDTF/GOSS-financed projects in 2006 could reach around \$130 million (GOSS 2006). This includes an estimated \$60 million in current annual public spending from various sources (including humanitarian programs such as the European Community Humanitarian Office [ECHO] disease-specific initiatives such as the Global Fund, and a USAID development program), an additional \$60 million from the MDTF/GOSS-financed Health Sector Umbrella Program, \$6 million for pharmaceuticals under the Rapid Impact Emergency Project,

and an estimated \$5 million for a hospital and MoH infrastructure under the Sudan Emergency Transport and Infrastructure Development Project (GOSS, 2006).

The \$130 million total would represent an increase in spending over prior years, from roughly \$10 per capita to approximately \$13 per capita.<sup>3</sup> The 2005 Joint Assessment Mission estimated that in order to increase *basic health services coverage* (for example, first-referral care only and not tertiary or humanitarian programs), required public spending on health would be around \$123.4 million in 2006 (or about \$14 per capita) and \$128.4 million in 2007 (JAM, 2005a).

The Interim Constitution stipulates that primary health care services will be provided free of charge. User fees for services and drugs have been a stated policy goal in earlier SPLM documents, and cost-sharing schemes were piloted in 2003–04 with mixed results. Especially noteworthy were the dramatic declines in attendance rates at some health facilities (Erasmus & Nkoroi, 2002).

## 2.4 Stewardship

Health authorities have minimal capacity at both central and county levels.

Following the Comprehensive Peace Agreement of January 2005 a Government of National Unity (GoS) was established on September 20, 2005, in which representatives of the South hold portfolios. In October 2005 a new Federal Ministry of Health for the Government of Southern Sudan was established and is based in Juba. WHO has been providing support to the ministry, and expatriate technical experts are being appointed to serve in the MoH. While the GOSS is to be responsible for overall policy and regulation and technical support, service delivery responsibility is expected to reside at the county level (JAM, 2005a) However, with little in the way of formal local governance currently in most counties and a general shortage of qualified personnel to draw on, the reality of functioning county health departments seems far off.

Health policy is focused on developing equitable sectorwide provision of health care. Through a series of health policies,<sup>4</sup> the SPLM SOH focused on strengthening PHC service, building institutional capacity building, and decentralizing responsibilities. However, these early policies were not realistically aligned with actual field conditions and were never put into operation (JAM, 2004). In anticipation of a peace agreement, the SPLM developed a health sector strategy (SOH & SPLM, 2004) that outlined key priorities and provided a foundation for the joint needs assessment. At the end of 2005, the Federal Ministry of Health formulated a new Interim Health Policy that outlined goals and defined rudimentary policy for 18 priority areas for the six-year interim period. The MoH approach is anchored on five core values: right to health, equity, pro-poor, community ownership, and good governance, with a stated mission of ensuring “equitable, sector wide, accelerated and expanded quality health care for all people in South Sudan, especially women and children.”

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<sup>3</sup> External assistance was approximately \$55 million in 2002, equivalent to \$7 per capita. Using this figure, the SPLM's Health Sector Recovery Strategy estimated a total resource envelope for health services at \$10-11 per capita (\$100-110 million) for 2005. Other sources note that the health sector resource envelope in previous years has been estimated at around \$60–80 million (GOSS, 2006).

<sup>4</sup> Health Policy for New Sudan (SPLM, 1994); Health Policy of the New Sudan (SPLM, 1998); National Poverty Eradication Strategy Concept Note (JAM, 2005b).

The Interim Health Policy identifies 10 top priority areas for resource allocation: 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; institutional development; human resource development; health financing; and health policy making, planning, monitoring and evaluation.

The MoH plans to pursue a two-track strategy, balancing the need for long-term capacity building and investment with the need for immediate intervention. Track 1 focuses on developing the health system's core capacities and track 2 on the immediate delivery of essential services to a significant proportion of the population (GOSS, 2006). Work is underway to develop a South Sudan Interim Health Strategy 2006–2008, that will provide the direction and scope of work in the health sector required to fulfill the Interim Health Policy. For this first period, emphasis will be on scaling up of PHC services, starting from the least served areas; strengthening the capacity of the health system and local health authorities; and supporting policy and regulation development.

Regulation and quality control mechanisms have been absent. The December 2005 Health Policy notes that annual monitoring and evaluation (M&E) and planning cycles will be developed at central, state and county levels. MDTF/GOSS funds were approved to establish a MoH M&E department that will gather data on health services from implementing partners to evaluate performance (GOSS, 2006).

## **2.5 Community engagement**

The MoH Interim Health Policy affirms that a community has the right to participate individually and collectively in the planning and implementation of its own health care and calls for community representation on management boards and committees at federal, state, and community levels. The draft BPHS proposes the creation of MoH-supported health committees, which will act as custodians of the agreement between the MoH and the community. According to the proposal, health committees will consist of elected community representatives and will also contribute to the planning and implementation of PHC activities. Selection of CHWs, community mobilization, encouragement of community-based initiatives, and infrastructure maintenance will also fall under the health committee's purview. The BPHS also notes that health committees will supervise local health services, including monitoring user satisfaction, presumably serving as the primary accountability mechanism between the community and the county health department.

Community health workers have long functioned as first-line clinical staff and therefore lack sufficient time to be highly involved in community-based health promotion activities. Acknowledging this, the draft BPHS calls for the creation of a network of village health volunteers (VHVs) to conduct health promotion activities and serve as resource persons for their communities. VHVs would be trained by the CHD and could also contribute to epidemiological surveillance, assist with active case finding, conduct follow-up of patients under long-term treatment, and, in some areas, implement Integrated essential child health care. The BPHS also suggests that existing trained traditional birth attendants should continue to be supported with refresher training, although they would not formally be part of the MoH system and staff.

## 2.6 Health service outputs and outcomes

Although there have been recent efforts to strengthen data and information systems, Southern Sudan health data remain incomplete and of limited quality. The GOSS plans to undertake a UNICEF-supported Health and Nutrition Household Survey in 2006. Working figures for key health indicators are largely based on data from the 2000 Multiple Indicator Cluster Survey, which covered three southern urban centers (Juba, Malakal, and Wau) under government control and the 1999 MICS, which covered SPLM-held rural areas. Health indicators vary considerably by region, with Equatoria and town centers such as Juba generally faring better. Data provided below are from the New Sudan Centre for Statistics and Evaluation (NSCSE & UNICEF, 2004), which has attempted to establish baseline estimates of key health indicators using all available data.

Immunization coverage is extremely low, with measles vaccination for 1 year olds estimated at just 25 percent, DPT3 coverage at 8 percent, and polio at 30 percent. The prevalence of acute malnutrition among under-fives has been estimated in excess of 15–20 percent in some areas and under-five chronic malnutrition is estimated at 45 percent. Estimated utilization of insecticide-treated bed nets is negligible, with less than 1 percent of under-fives sleeping under a net.

An estimated 84 percent of women did not receive any antenatal care during their last pregnancy; in Bahr el Ghazal, almost none of the women (0%) received ANC. Most births occur at home, with just 5 percent of deliveries conducted by skilled birth attendants.

Communicable diseases are the major causes of morbidity and mortality, with malaria accounting for a high proportion of the disease burden. Frequent infectious disease epidemics, high malnutrition levels, and the specter of rising HIV/AIDS incidence in conjunction with a returning population and a developing country infrastructure also pose formidable challenges to improving health status. HIV/AIDS prevalence among adults is unknown, but Southern Sudan is believed to have a generalized epidemic. Small regional studies indicate rates between 0–8 percent, with prevalence highest in the border areas. UNAIDS estimates prevalence of 2.6 percent for the country as a whole. TB incidence is estimated at 325/100,000.

Under-five mortality was roughly estimated at 250 per 1,000 (NSCSE & UNICEF, 2004) and infant mortality at 150 per 1,000 (NSCSE & UNICEF, 2004). Southern Sudan has one of the highest estimated maternal mortality ratios in the world, at 1,700 deaths per 100,000 live births in 2000 (NSCSE & UNICEF, 2004).

## 2.7 Findings and discussion

The situation is bleak—

- Heavy communicable disease burden, especially malaria, along with high prevalence of tropical diseases that is largely controlled in other countries
- Little in the way of a pre-existing system to build on
- Extremely limited capacity, absorptive and resource constraints, particularly human resources
- To the extent there is a health system, it is largely run by CHWs
- Health service coverage is also dependent on progress in other areas (development projects, roads, and infrastructure)

- Reality on the ground (returnees and ongoing insecurity) may continue to result in a predominance of ad-hoc humanitarian programs
- Increases in financial resources may not have a significant impact if large operational costs (including security and transport) continue to limit both provision and access to services.

The general approach is appropriate and builds on international experience—

- But will need *significant* technical support and capacity building to put into operation.
- The county or community level will shoulder the burden for service provision, but it is not clear that adequate support is going to be provided to enable them to deliver.
- Emphasis has been placed on a moderate speed for expansion—ensuring quality of services and not just coverage. At the same time, the health policy's stated aim is to push for equity and expansion of service provision to peripheral areas that have long been neglected. It is not clear how authorities will effectively reconcile competing priorities in practice.

## 3 The Role of International Development Partners

### 3.1 Inventory of key actors

Major bilateral and multilateral donors suspended normal aid relations and long-term development assistance to Sudan in 1990–91. Since then, more than 80 percent of assistance has been in the form of humanitarian relief, with many donors<sup>5</sup> channeling large aid flows through the plethora of UN agencies and NGOs operating in the region. The bulk of assistance was provided through Operation Lifeline Sudan (OLS), the UN-led humanitarian program involving more than 43 NGOs that began operating in 1989.

In 2002, following a decade of extremely difficult and at times hostile relations, the U.S., the U.K., and Norway began to reengage directly with Sudan, following the east African states' InterGovernmental Authority on Development (IGAD) efforts to negotiate a peace settlement. These three donors (the Troika), together with the EC, the Netherlands, and Italy have subsequently led funding of recovery and CPA-related programs, including health sector support. USAID in particular has played a lead role in humanitarian and development spending, jumpstarting development programming by initiating a \$46.5 million "Health Transformation Project" in 2004 that was aimed at strengthening county health departments for the provision of PHC services (USAID, 2005b). Under the UN Work Plan, 10 major bilateral donors, 17 NGOs, and 5 UN agencies are currently supporting health sector projects in Southern Sudan.

After a decade of withdrawal, the World Bank began reengaging with Sudan in July 2003 and reopened its Khartoum office in August 2005. While the World Bank has been providing technical assistance and support to the GOSS, the GOSS has not financially reengaged with Sudan, and the country is not currently allowed to borrow from the International Development Association (IDA) to which it is in arrears.<sup>6</sup> Sudan remains in a similar situation vis-à-vis the African Development Bank. Because it may still be some time before Sudan is eligible for IDA or IMF support, rehabilitation and reconstruction efforts have been dependent on UN and bilateral sources for funding.

The Global Fund for AIDS, TB and Malaria is supporting a \$27.5 million portfolio of projects for the three diseases in Southern Sudan, with the United Nations Development Programme (UNDP) as the principal recipient. To date, \$3.7 million has been disbursed for a five-year HIV prevention and care program, \$4.03 million for prevention and control of tuberculosis, and \$8.02 million for malaria. (Separate proposals support HIV/AIDS and malaria programs for the northern sector.)

GAVI has provided vaccine support for hepatitis B, injection safety, and immunization services support since 2000. Total committed support is \$13.8 million for all of Sudan for five years.

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<sup>5</sup> Including the Belgium, Canada, European Union, Finland, Germany, Italy, Japan, the Netherlands, Norway, Sweden, Switzerland, the U.K., and the US.

<sup>6</sup> With approximately \$26 billion in current external debt, debt relief for Sudan has been an important issue and point of leverage in the peace process. Although the IMF and other multilateral agencies have been working on developing a debt relief process, the ongoing crisis in Darfur has remained an impediment to negotiations for many donors. Once arrears have been cleared, Sudan will be eligible for debt relief under Heavily Indebted Poor Countries (HIPC).

Annex 1 lists the major health sector international development partners (UN Agencies, INGOs and donors) operating in Southern Sudan.

### **3.2 Harmonization and alignment approaches**

#### ***Strategic planning and coordination frameworks***

A combination of planning and aid coordination frameworks was employed leading up to and following the CPA; these included joint needs assessments, transitional results matrix (TRM) and consolidated appeals. Norway has facilitated piloting of the Development Assistance Committee (DAC) principles for good international engagement in fragile states (Development Co-operation Directorate [DCD], 2005).

The Joint Planning Mechanism (JPM), a post-conflict recovery planning process, was created in May 2003 under the guidance of the World Bank, USAID, the UN, and the IMF. Under the JPM, the SPLM and GOS assessed rehabilitation and transitional recovery needs, developed priorities, and drew up action plans for the pre-interim period. The World Bank, GoS, and the SPLM also agreed to create a joint secretariat in Nairobi by August 2003 that would be facilitated by the UN system and would assist in coordination and harmonization of priority areas (World Bank, 2003a).

Starting in January 2004, the JAM for Sudan began estimating Sudan's short-term (2.5 years) needs, as well as developing a longer-term framework for recovery and reconstruction over the six-year interim period, oriented toward the Millennium Development Goals. Jointly led by the World Bank and UNDP, the JAM took a year to complete and was guided by a Core Coordinating Group comprised of representatives from the GoS, the SPLM, World Bank, the UN system, as well as IGAD and IGAD Partners Forum for Peace. Eight "cluster" areas were selected, and experts were identified to work with the SPLM and GoS to conduct detailed needs assessments for each area. The development of the Transitional Results Matrix format was integrated into the JAM and used to structure the results of the needs assessment (United Nations Development Group [UNDG] and World Bank [WB], 2005). For example, pre-JAM training events and capacity-building workshops were held to develop a framework for linking actions, outputs and outcomes. The JAM resulted in the Framework for Sustained Peace, Development and Poverty Eradication, which was endorsed by the World Bank, UN, GoS, and SPLM and presented to donors in Oslo in April 2005.

The JAM's health sector needs assessment produced the Southern Sudan Health Sector Working Paper, which drew on the SPLM's 2004 Strategy for the Recovery of the Health Sector, and was integrated into the JAM Basic Social Services Cluster Report (JAM, 2004). The JAM also incorporated a separate assessment of HIV/AIDS as a crosscutting issue.

The major umbrella mechanism set up for donor coordination is the Sudan Consortium, which comprises all major stakeholders in Sudan, including representatives from the Sudanese governments, donors, UN agencies, and civil society groups. Established through the CPA and the Oslo donors' conference, the consortium is charged with achieving national consensus on humanitarian and reconstruction strategic priorities and reviewing overall program developments. The group is set to meet for the first time in early March 2006 (IRIN, January 18 2006).

A Health Sector Coordination Mechanism, the Health and Nutrition Consultative Group, was established in September 2005 and is chaired by the SOH/MOH with secretarial support through WHO. Membership is comprised of: UN health agencies, donor health advisors, INGOs (2), national NGOs (1), and faith-based organizations (1) (WHO, 2005d).

To coordinate coverage of the multiple areas in need of acute assistance across Sudan, the UN Office for the Coordination of Humanitarian Affairs (OCHA) has led development of reinforced consolidated appeals and annual work plans. In 2004, the Consolidated Appeal for the Sudan Assistance Plan (ASAP) requested \$720 million for Sudan. In November 2004, by the UN and partnering donors and aid agencies developed an annual work plan, with the aim of integrating all relief, recovery, and development action plans to be addressed in a one-year time frame for the whole of Sudan. The work plans have been developed in consultation with the GoS and the SPLM/A, drawing on their identified priorities to identify strategic themes. Regional sector plans outline specific objectives, strategies, indicators and supporting projects. The 2005 Work Plan initially sought \$1.5 billion to support 304 projects, over \$550 million of which was for immediate recovery, development and humanitarian programs in the southern part of the country. The 2006 Work Plan requested \$1.5 billion for humanitarian assistance, and an additional \$210 million for recovery programs. This included \$50.4 million to support health sector projects in Southern Sudan (United Nations, 2006)

### ***Financing and delivery mechanisms***

As a precursor to the multi-donor trust fund, the UN and the SPLM established the Capacity Building Trust Fund for Southern Sudan in January 2004 to fund recurrent costs (health workers, administrative staff) and operating expenses of the new government, capacity building, and institutional strengthening, and quick start impact programs during the period until the CPA became fully operational and new institutions were established (UNICEF, 2004). UNICEF was designated fund custodian on behalf of the UN and donors.

The establishment of two MDTFs—one for the North and one for the South—was conceived as the principal funding mechanism for supporting recovery and CPA-related programs, combining resources from both external donors and the GOSS to support “mutually-agreed development priorities.” Under the CPA wealth-sharing protocol, the MDTF-South is to be transformed into the Southern Sudan Reconstruction and Development Fund after an interim period.

More than 60 countries and international organizations attended the April 2005 Oslo Donor Conference for Sudan, which raised pledges of \$2 billion towards the \$2.6 billion in development and reconstruction needs documented in the JAM (Odin Archive, 2005); \$508 million of this was pledged towards the two MDTFs, to be administered by the World Bank. The Netherlands made the largest initial pledge to the fund (\$195 million), followed by Norway (\$100 million), and the UK (\$80 million). To date, \$484 million has been committed to the funds for the period 2005–07 by Denmark, the EC, Finland, Greece, Iceland, Netherlands, Norway, Sweden, and the UK (World Bank 2006). The MDTF became operational in June 2005, and the first MDTF money was disbursed in late November 2005, providing a \$27 million emergency package (\$20 million grant from the MDTF-S plus \$7.25 million from the GOSS) to rebuild health and education services and support basic government functions in Southern Sudan (IRIN, January 18 2006). Late in 2005, the Health Sector Umbrella Program submitted an initial project proposal to the MDTF Interim Oversight Commission for consideration. The proposal, developed by the SoH/FMoH, GOSS, the World Bank, and WHO, includes \$7 million for UN special programs. Significantly, the Health Sector Umbrella Program specified that two-thirds of funds for health sector programs are to come from the GOSS’s own resources (\$84 million out of a total \$126 million). This obviously is contingent on GOSS getting their full share of the oil revenues from the GoS (WHO, 2005c).

A recent addition to the mix of aid instruments in Sudan is the Common Humanitarian Fund (CHF). Pooled contributions are made available to meet immediate or neglected humanitarian needs outlined in the Work Plan. The humanitarian coordinator allocates funds, with the approval of an advisory board that includes the UN country team, donor, and NGO

representatives. The CHF is able to disburse funds much more quickly than the MDTF, and the mechanism is seen as a method for avoiding key gaps in coverage resulting from the slow arrival of funds (as occurred in 2005) (UN OCHA 2006). Donors currently supporting the fund include Ireland, Luxemburg, Netherlands, Norway, Sweden, and the UK. As of February 2006, \$106 million was allocated through the CHF and disbursed to 11 UN agencies and 34 NGOs to cover early implementation programming costs outlined in the Work Plan, which required emergency funding by the start of year.

### ***Challenges in operationalizing harmonization and alignment strategies***

While there have been concerted efforts to coordinate the influx of humanitarian and development assistance, the process was hindered early on by the delay in CPA implementation and establishment of the GOSS. Overall, the 2005 Work Plan was massively under-funded and delivery of resources was slow. The recent creation of the CHF has been one attempt to remedy funding delays. In addition, there were some criticisms that the 2005 Work Plan process did not sufficiently involve local actors. For example, one report noted that “insufficient consultation with Sudanese stakeholders,” resulted in “a disconnect between plans, realistic funding support and the actual feasibility to deliver and implement the plans” (IRIN, January 18 2006). The fact that most agencies and organizations maintain their offices in Nairobi likely exacerbates the gulf between the decision-making sites and the affected service delivery areas.

Health sector coordination was particularly slow to get underway in 2005, and the sector was constrained by limited and late funds, receiving just 48 percent of the required funds documented in the Work Plan (\$28.7 million received of \$58.7 requested for Southern Sudan). Of this amount, 23 percent was earmarked for the measles vaccination campaign to begin in November 2005 (UN OCHA, 2006).

There is yet not much experience on the ground level of shadow alignment apart from the MDTF, which is still in the initial phases of disbursing funds. A second issue is the alignment of service provision activities of the NGOs in areas such as treatment protocols.

### **3.3 Dealing with key tradeoffs: saving lives versus building capacity**

The SPLM and JAM assessments acknowledged that finding the right balance between needed humanitarian assistance and health system recovery would be the primary challenge facing health sector partners (JAM, 2004; JAM, 2005a). In recent years, over 80 percent of all ODA has been driven by humanitarian needs. With large influxes of returnees into southern states, ongoing pockets of insecurity, and the opening up of previously inaccessible areas in 2005, humanitarian assistance has remained essential and continues to be the principal aid mechanism for Southern Sudan. According to an interview with the Humanitarian Coordinator at the start of 2006, “almost all service delivery in South Sudan was funded by humanitarian assistance, rather than through development assistance or programs of the Government of Southern Sudan” (IRIN, December 2 2005). Prior to the CPA, the United States was the only bilateral donor providing substantial funds for development in SPLM-administered areas (USAID, 2005a).

With slower-than-planned CPA implementation in 2005, donors also continued to respond more forcefully to humanitarian needs. Across all sectors of the 2005 Work Plan, humanitarian action was the best-funded category of assistance for Southern Sudan, receiving 59 percent of

required funds, while development assistance (including all MDTF contributions) achieved only 5 percent coverage (UN OCHA 2006). On the one hand, partners have expressed concerns about inadequate support of CPA-related programs because of an ongoing emphasis on humanitarian programs; while on the other hand, partners have worried that reductions in humanitarian assistance in favor of increased development funding would adversely impact service delivery in the short term (UN, November 30 2004).

Planning documents have underscored the need for combined approaches. The JAM/TRM specified outcomes and indicators according to a phased approach, with indicators defined at baseline and for each time point. In phase 1 (2005–06), goals focus on immediate recovery and reconstruction, acknowledging that humanitarian needs would continue to persist (or even increase) in the short term (JAM, 2005a). In phase 2 (2007–10), emphasis is on a full development strategy, with the goal of establishing “an integrated system for the delivery of health services at the county level.” To achieve this, the JAM health needs assessment recommended a two-pronged strategy “emphasizing interventions that would provide ‘Quick Wins’ and contribute to a tangible peace dividend,” while simultaneously strengthening longer-run development programs through “a massive emphasis on capacity building activities and institutional development during the first two years” (JAM, 2005a).

Proposed Quick Win programs include measles vaccination and Vitamin A supplementation campaigns, insecticide treated net distribution, and other campaigns related to HIV/AIDS and family planning (WHO, 2005c; JAM, 2005a). Other “first track” priorities include the development of a BPHS, to be implemented via contractual agreements with international and local NGOs. The BPHS model is expected to set out a framework for shifting project-based service provision under a national umbrella. With its development, donors will also be expected to move from individual project-based support to funding a more holistic sectoral strategy. For example, it is recommended that the Global Fund will need to “change to funding disease-specific elements of the BPHS, either through the MDTF, or funding individual actors who implement the BPHS” (WHO, 2005b; JAM, 2005).

### **3.4 Measures to ensure client participation in needs assessment, ownership, and donor accountability**

Starting in 1999, the SPLM and the Sudan Relief and Rehabilitation Association (SRRA) took measures to develop services and build capacity of local authorities in the health sector and in local NGOs. The SPLM/SRRA developed Memorandum of Understanding with INGOs, which required accountability to the local SRRA office and transparency of resources, and allowed the SPLM some approval power over NGO projects and hiring decisions (Lehtinen, 2001; Newell-Jones, 2004). With this background, Southern Sudan has generally been considered to have strong leadership and demonstrated willingness as a partner government (Overseas Development Institute [ODI], 2004).

The JAM structure set up clear SPLM and GoS counterpart roles for the needs assessment. Participatory training efforts were incorporated into the JAM and the results framework specified capacity-building requirements for designated time intervals (United Nations Development Group [UNDG] & World Bank [WB], 2005) However, there were some complaints from civil society that civil society organizations were marginalized, not adequately consulted or informed during the peace process, and not provided sufficient access to institutional or financial support independent of government structures (Sudan Civil Society Forum, 2005). The JAM did issue a

concept paper on the role of civil society organizations,<sup>7</sup> and the health assessment notes that one group, the New Sudanese Indigenous NGOs (NESI-Network) was consulted during the JAM.

The MDTF was designed in the CPA to be a support mechanism for the GOSS, with the GOSS having decisive influence over which programs to support.<sup>8</sup> Because the GOSS will not, in point, lack financial resources of its own—it will derive considerable funds from oil revenues under the wealth-sharing protocol<sup>9</sup>—it perhaps has greater leverage than other transitional governments to drive priority setting for the use of MDTF resources. However, it is not clear to what extent all international partners have agreed to work through this financial system. In the CPA, it was expected that international funding for development activities would be predominantly channeled through the MDTF; however, a large proportion of assistance has not been channeled through the fund. The largest donor of all, USAID, has directed the bulk of its assistance bilaterally to implementing partners, NGOs, and contractors. There is no contribution yet noted of the US to the MDTF.

In the health sector, given the limited capacity of the GOSS to provide services for the foreseeable future, emphasis has been placed on building the MoH's policy and oversight capacity. It is expected that the BPHS model will increase government ownership of the process, facilitate improved donor coordination, and improve funding transparency and accountability.<sup>10</sup>

Some financial tracking, monitoring, and accountability mechanisms were also established. In 2003, OCHA conducted a baseline survey of donor assistance and developed a Resource Tracking System to provide detailed information and statistics for all international humanitarian and recovery assistance in Sudan. More than 80 reports are generated and made publicly available from data supplied by donors and international partners on activities inside and outside the Work Plan framework (see [www.unsudanig.org/rts/2005/](http://www.unsudanig.org/rts/2005/)). No information was found on plans to scale-up these systems to state levels or to incorporate them into national information management systems.<sup>11</sup>

### **3.5 Supporting the provision of services to marginalized groups**

In the past, severe discrimination in service provision has occurred on political, social, and geographic levels in Southern Sudan, with overall coverage of basic health services estimated at only 25 percent (JAM, 2005a). At the Oslo conference, Sudanese women issued a declaration, calling on donors to commit to “principles of gender responsive resource allocation” such that 80 percent of reconstruction budgetary allocations and resource support would meet three of four criteria: directly benefits women (including access to resources), reduces gender inequalities, directly benefits young people, and targets rural areas. Women also requested that

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<sup>7</sup> See <http://www.unsudanig.org/JAM/output/data/CivilSoc/NGO-strategy.doc>.

<sup>8</sup> Odin archive, 2005.

<sup>9</sup> The JAM estimated that oil will be a large factor in Southern Sudan's economic recovery, contributing more than 50 percent to the GNP in 2008 (JAM, 2005a)

<sup>10</sup> See <http://odin.dep.no/odinarkiv/norsk/ud/2005/taler/032171-090377/dok-bn.html>.

<sup>11</sup> See [www.unsudanig.org/JAM/background-info/data/keydocuments/needs-assessment-WP1.doc](http://www.unsudanig.org/JAM/background-info/data/keydocuments/needs-assessment-WP1.doc).

donors' support an all-inclusive Sudanese Women's Conference to define a long-term agenda and strategy for achieving gender equality.<sup>12</sup>

Importantly, the health sector focus has been on developing a BPHS approach and the provision of no-cost essential health services, which certainly supports pro-poor service delivery. The JAM cluster report also suggested that, to facilitate rapid coverage expansion, NGOs should be offered incentives for working in the most difficult areas, starting with mobile teams.

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<sup>12</sup> See [www.unifem.org/attachments/events/SudaneseWomenStatementToOsloDonorsConference.pdf](http://www.unifem.org/attachments/events/SudaneseWomenStatementToOsloDonorsConference.pdf).

## **4 Lessons Learned and Recommendations**

### **4.1 Fragility and health service delivery**

It is difficult to be very optimistic about the prospect for short-term rehabilitation of Southern Sudan's health sector. To begin with, *rehabilitation* may be an inappropriate word because there has never been a routinely functioning health system in the country. There are few health workers to be retrained, few facilities to be rebuilt, and not even a skeletal management staff to be retrained. This is essentially a case of starting from scratch, and other models may or may not be appropriate to the unique context of Southern Sudan.

What does exist in the health sector of Southern Sudan is an overly long history of humanitarian relief, with all its inefficiencies and relative lack of coordination. The situation has been characterized by scores of NGOs operating on the ground with little government oversight, very poor transportation and communications infrastructure (with drugs and other commodities flown in via Operation Lifeline Sudan), and remarkably low coverage levels for even basic health services. Humanitarian assistance tends to be quite expensive, even in countries whose infrastructure is far more developed. Thus, despite the fact that annual per capita investments in health have been reasonably high in Southern Sudan, they have yielded small returns. As a result, health parameters in the country are among the world's worst.

The health system's poor state is also a function of other drivers of fragility, the most of important of which is the political situation, presented in chapter 1, above. The basic problem is that building an effective health system in Southern Sudan is a long-term proposition that will undoubtedly require consistent and predictable donor funding at appropriate levels for many years. This will not be possible if there is a resumption of hostilities between the South and North. In addition, Southern Sudan will have to establish itself as an economically viable state, which a distinct possibility in view of its substantial oil reserves. Again, however, this will not be possible without the full cooperation of the North and a bilateral respect for the Comprehensive Peace Accords. It therefore makes sense for donors that are interested in strengthening Southern Sudan's social sectors to be intensely interested in maintaining a stable political environment.

### **4.2 Health sector adaptations**

The humanitarian needs of Southern Sudan remain enormous. It will be a considerable challenge for the international community to achieve both humanitarian and political objectives, while participating in and helping to guide the development of a new country. Very limited human resources are a by-product of the country's newness and represent the health system's biggest constraint at all levels, including: central management and administration, county health offices, and clinical health service provision. Obviously, this is a problem that will take some time to resolve. There have been attempts to fill the human resource gap by training (for example, USAID's Capacity Project and public administration training, aided by Bearing Point), as well as incentives offered to returning refugees and a large number of projects funded by other donors. Still, there seems to be no alternative to expatriate technical assistance to provide stopgap support.

Stopgap assistance will need to take two forms. First, technical assistance should be provided at all levels of the Ministry of Health. WHO and other donors have already developed plans to post advisors, a step that requires careful coordination, as experience has shown. Here, as in

other areas, it is important that GOSS needs be met, as opposed to potential donor efforts to gain influence or position.

Secondly, as has been the case for many years, it is likely that the private sector will have to deliver service provision. Interesting and reasonably successful experiences in this area are being gained in other post-conflict states, including Afghanistan, Cambodia, and the Democratic Republic of Congo, where the public sector is contracting with indigenous and international private sector entities. This experiment should be, and is being, repeated in Southern Sudan. Emphasis will have to be made on improving the Ministry of Health's ability to competently and efficiently manage contracts. This is a major challenge in Southern Sudan because the few existing public sector managers are already stretched thin. Careful attention to terms of reference and careful oversight to NGO performance—especially in regard to adherence to the Basic Package of Health Services, when it is finalized—will be important to ensure competent service delivery of appropriate services and avoid waste.

A third health sector adaptation should and will be to contribute to the implicitly promised “peace dividend” through the implementation of a series of “quick impact projects” (QIP) that are both highly visible and appreciated by the population, and that can aid in establishing the legitimacy of the fledgling government, which was recently shaken by the death of its charismatic leader, John Garang. The art of QIPS is to have whatever projects are selected represent early accomplishments on the way to clearly envisioned and enunciated longer-term goals. Examples of these include the distribution of impregnated bed nets as an integral part of a comprehensive longer-term malaria control program or a mass measles vaccination campaign that puts the pieces of a cold chain in place while a more comprehensive routine expanded program of immunization is being established and expanded. It is possible that the most effective approach would be to build, stock, and staff new health centers in areas of strategic importance—people tend to like things they can touch and that become at least semi-permanent features of their local landscape. While the simultaneous achievement of both humanitarian and political objectives should be the goal of these interventions, community-based research is needed to determine what interventions might yield the best combination of results in these two areas.

### **4.3 Accessibility, availability, acceptability, and quality of services to marginalized groups**

As mentioned above, it is currently impossible to satisfy the needs of Southern Sudan's relatively dispersed population. There are little more than 500 primary health care units (really, first-aid centers staffed by nonprofessionals), 100 primary health care centers, and 19 hospitals for a population of 7.5 to 8.5 million. Today, probably only 25 percent of the population has access to any health facility and, with the transportation and communications networks as rudimentary as they are, there is little prospect for major improvement in the short timeframe, which usually characterizes post-conflict donor programming. For this reason alone, expectations need to be modest.

In addition, although there has always been major deprivation among all population groups in Southern Sudan, the notion of equity is problematic in this setting. Evenly dividing new health resources or evenly distributing them as a function of need may satisfy the humanitarian objectives of public health without necessarily contributing to the process of political stabilization. In fact, USAID seems to feel that it is more appropriate to provide a higher level of services to those few areas where some services had been available prior to the signing of the Peace Accords. Recently, USAID shifted the geographic focus of its health sector development project from 20 southern counties to the three transitional areas and three garrison towns where at least a rudimentary North Sudanese-administered health system was functioning. The

rationale is that those are the areas from which a resumption of hostilities is most likely to occur and, therefore, where the benefits of a “peace dividend” are most likely to yield beneficial results in the short term.

As for the acceptability and quality of services, they will be highly suspect for some time. The lack of management personnel may even represent a challenge to the ability of NGOs, local or international, to provide consistent, appropriate, regulated health services. Serious adaptations will have to be made to the context.

#### **4.4 Adaptations by international development partners**

It has been pointed out that expectations need to be modest. The Multi-Donor Trust Fund is well conceived, but will need careful attention if its implementation is to progress on schedule. The transition from humanitarian relief to development mode will have to be managed carefully. It goes without saying that coordination, cooperation, and harmonization among donors will be required for the GOSS to maximally benefit from donor input. As is always the case, some donors will invest more heavily directly in government efforts, while others will try to work parallel to government, while “hedging” their own investment until the stability and capability of the GOSS become clearer. Still, recent developments have upset the donor community, not the least being the perceived sudden shift of USAID’s geographic focus and its perceived withdrawal of the basis on which its development project (Sudan Health Transformation Project) was designed. Promised grants to NGOs in the southern counties apparently will not be made and drugs promised by USAID will not be procured, according to some sources. As a result, all donors and the GOSS need to revisit their plans and programs, and adjust them accordingly. Communications between funding sources in settings like Southern Sudan are critical, but donor harmonization has not proceeded smoothly at all to this point, making the possibility of measurable progress within Southern Sudan’s health sector even more problematic than need be the case.

The problem has not only been within the donor community. Appointments within the Ministry of Health have been slow and, clearly, the move from Nairobi to Juba has been predictably disruptive. With the rainy season now having begun, progress for the next few months promises to be elusive. However, there is an opportunity for serious consultation and analysis, for bringing all donors together with the GOSS, and for plotting a short-term strategy that would sit squarely within an agreed-upon long-term vision.

#### **4.5 Conclusions and recommendations**

1. The most important recommendation in terms of implementing service delivery in fragile states is for donors to become more serious about harmonizing efforts and aligning with the GOSS health care strategy, as it develops. The lack of communication between donors, not only on a programmatic level, but on a conceptual one as well, has clearly created problems. Although, of course, every donor has a reason for its actions. Southern Sudan is a country in which the “Principles for Good International Engagement in Fragile States” are being implemented, and all donors should take seriously the recommendations of whatever reports become available in this context.
2. Given its severe human resource limitations, the GOSS could greatly benefit from the posting of expatriate advisors or third country nationals at all levels of its health system. Again, donors and the GOSS need to coordinate these inputs, and an emphasis should be

placed on using technical assistants at the central and country levels to strengthen the MoH's managerial capacity.

3. Those donors that place an emphasis on political objectives, in addition to humanitarian ones, should communicate these well to all parties concerned, especially where implementation entails a shift in geographic focus, in resources, or in the content of health programs. Every programmatic change that one donor makes has implications for the others, as well as for the GOSS.
4. To achieve a visible and beneficial peace dividend, the GOSS and its partners should invest in infrastructure development early on—in roads, communications, wells, electricity, drug supply lines, and governance structures. Without investing now in a solid foundation, Southern Sudan's health system is likely to remain makeshift for quite some time.
5. A viable consumer-oriented health system framework should be established. This most likely would involve public sector management of private sector service delivery. The MoH needs to make clear decisions regarding its health objectives. Most probably, a contracting mechanism is most suited to the circumstances. Technical assistance needs for both the MoH for contracts management and to NGOs to ensure competent service delivery should not be underestimated.
6. Arrangements need to be made to improve the competence and the number of health staff available in the country. Human resources development is not something that can be rushed, but it should be started as soon as possible. Both in-country and external professional training should be supported.
7. Although GOSS can be said to be wealthy on the basis of the terms of the Comprehensive Peace Accords, the availability of financial resources does not translate into strong and effective health programs. The GOSS has said that it would provide two-thirds of the costs of the Multi-donor Trust Fund, but this needs to be carefully monitored. The proposed MDTF funding level must be met, of course, but it is also quite important to monitor the annual per capita investment in the health sector to ensure that the MDTF amounts are appropriate. In an environment with as poor an infrastructure as Southern Sudan, where air transport is required for the delivery of most goods and commodities, even relatively large sums of money can yield only modest results. Donors should not hesitate to increase their allocations if acceptable progress is being made as determined by an effective monitoring system, and if improvements in social sector service delivery seem to having a desirable impact on maintaining political stability.

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