



Research Report

Beyond the Health Governance Gap Maternal, newborn and child health in South Sudan

By Sebastian Taylor

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Contents

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Particular gratitude is due to the Republic of South Sudan, its Ministry of Health and counterparts in Warrap State, the staff and partners of World Vision South Sudan, and the range of respondents who agreed to participate through interview or group discussion.

Cover image: Eighteen-year-old mother Teresa, with her one-year-old child Catherine, hopes that in the new South Sudan more health facilities will be built closer to communities. © 2011 Joyce Mulama/World Vision

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Abbreviations

ACF	Action Contre la Faim	MDG	Millennium Development Goal
ANC	Antenatal Care	MDTF	Multi-Donor Trust Fund
BEmONC	Basic Emergency Obstetric and Neonatal Care	MMR	Maternal Mortality Rate
BPHS	Basic Package of Health Services	MNCH	Maternal, Newborn and Child Health
BSF	Basic Services Fund	MNRH	Maternal , Newborn and Reproductive Health
CBO	Community-based Organisation	MoH	Ministry of Health (Juba)
CCT	Conditional Cash Transfer	NNMR	Neonatal Mortality Rate
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care	ODA	Official Development Assistance
CHF	Common Humanitarian Fund	OECD-DAC	Organisation of Economic Cooperation and Development – Development Assistance Committee
CHO	County Health Officer	PBF	Performance-based Funding
CHW	Community Health Worker	PHCC	Primary Health Care Centre
CMR	Child Mortality Rate	PHCU	Primary Health Care Unit
CPA	Comprehensive Peace Agreement (Naivasha)	RoSS	Republic of South Sudan
DFID	Department for International Development (UK)	SHHS	Sudan Household Health Survey
DHEP	Department for Health Education and Promotion	SMoH	State Ministry of Health
GINI	Gross National Income	SSAF	South Sudan Armed Forces (the new name for the SPLA)
GoSS	Government of South Sudan	SPLM	Sudan People's Liberation Movement
HFSN	Health in Fragile States Network	SRF	Sudan Recovery Fund
HHP	Home Health Promoter	RRC	Relief and Rehabilitation Commission
HPF	Health Pooled Fund	TBA	Traditional Birth Attendant
HSDP	Health Sector Development Plan	UNDP	United Nations Development Program
ICG	International Crisis Group	UNFPA	United Nations Population Fund
IMCI	Integrated Management of Childhood Illness	USAID	United States Agency for International Development
IMNCI	Integrated Management of Neonatal and Childhood Illness	WFP	World Food Programme
IMR	Infant Mortality Rate	WHO	World Health Organisation
INGO	International Non-Government Organisation	WV	World Vision
		WVSS	World Vision South Sudan

Preface

In September and October 2011, the DLgroup was contracted by World Vision UK, Australia and South Sudan to carry out a scoping study on maternal, newborn and child health (MNCH) in South Sudan. The purpose of the study was: to explore the major drivers of poor MNCH in South Sudan; to look at gaps in knowledge (or effective implementation) with regard to those drivers; to identify priorities for World Vision policy advocacy (including research priorities); & to map out important actors in the development of such policy advocacy.¹

Although originally conceived as an internal paper to World Vision, World Vision made the decision to publish it as we feel that it provides important new insights into the key drivers of poor Maternal and Child Health in South Sudan. We hope that these insights will help shape and inform ongoing debates, planning and interventions in the sector amongst government actors, donors, think-tanks, the NGO community and beyond.

Gratitude is due to the Republic of South Sudan (RoSS), its Ministry of Health (MoH) and counterparts in Warrap State, the staff and partners of World Vision South Sudan, and the range of respondents who agreed to participate through interviews or group discussions.

Methods, scope and limitations

This study uses both primary and secondary data. It includes a desk-based review of relevant literature on MNCH in fragile contexts, as well as on post-Comprehensive Peace Agreement conditions in South Sudan, and on South Sudanese approaches to health system strengthening in general and MNCH in particular. This is complemented by quantitative and qualitative information gathered during a 2-week field visit to South Sudan (Juba and Warrap State), largely using a semi-structured interview format. The study was completed over a relatively short period of time.

This study is not intended to provide an exhaustive or conclusive assessment of the drivers of poor MNCH in South Sudan. Rather, analysis and observations offered should be taken as indicative – they point towards areas where consensus among stakeholders is emerging, to areas where distinct differences of view remain, and to areas in which the evidence on the ground suggests the prioritisation of certain elements of policy and programming. A principal feature of the report is the identification of areas in which further, more substantial research could be developed as a means to strengthening both policy-thinking and programme and project design to improve MNCH in South Sudan.²

¹Terms of Reference, Annex I.

²Efforts were made to ensure that a representative spread of respondents in the field-based stage; however, not all relevant actors were on hand for interview in the time available. Whilst the report attempts to synthesise common patterns in data gathered to achieve an accurate overview of MNCH issues and current responses, the analysis and resulting observations are those of the consultant and cannot be taken to represent views of stakeholders, including World Vision, unless otherwise indicated.

Executive Summary

After almost half a century of sustained conflict, South Sudan has emerged as the world's newest nation. It has little in the way of infrastructure (roads, electricity, water/sanitation, health centres, schools, etc.). Its population is largely rural, often remote, mainly illiterate and extremely poor.

Many people interviewed for this study – government, donors, UN and INGO partners – describe South Sudan as 'starting from zero'. But there is space for optimism. Today, South Sudan represents an unusual opportunity to rebuild the country, its systems and its communities in a way that forges a path out of conflict recognising the interconnectedness of security and citizen well being.

South Sudan has some of the worst indicators for maternal, newborn and child health (MNCH) in the world. Over 2,000 women per 100,000 die in childbirth each year. One in 10 babies born in South Sudan will not live to see their fifth birthday, with almost half of all under-five deaths occurring within the first month of life and 80% within the first year of life³. Access to care among pregnant women and young children is very low, at between 20% and 40% of need, with a likelihood of still lower rates for dispersed villages. Family planning and wider attention to sexual health are negligible elements of local health practice and systemic support.

The health of mothers and children matters to families, and it should matter to states. The moral case for saving these lives hardly needs to be made. Donors and governments around the world have signed up to MNCH as a core component of the Millennium Development Goals, and in line with the International Covenant on Rights, governments should enable the realisation of the rights of women and children to the 'highest attainable standard of health'⁴. Beyond matters of principle though, there are also solid pragmatic reasons to prioritise MNCH. Reducing maternal and child mortality and morbidity saves money, and contributes to growth in GDP. More tentatively, but importantly, there is an emerging view that delivering services such as health can contribute positively to community perceptions of support and protection, especially after long years of conflict, which build citizens' confidence in government as it, in turn, rebuilds the state.

How then, is the crisis of MNCH to be addressed? It is now widely accepted that the macro-drivers of population health lie in the social, political and economic conditions in which people live – the governance values which shape the policies, which determine the resources that flow into people's material circumstances and life chances. In South Sudan for example, entrenched gender inequity influences access to resources as well as social practices that maintain the appallingly high risks girls and women bear in reproduction. Action on these drivers will be vital to long-run improvement in safe motherhood and child survival. But the need in South Sudan is urgent. This paper argues, therefore, that improving MNCH in a timeframe that is meaningful to families depends centrally on strengthening and focusing health care in ways that bring quality services within people's reach allowing them to experience their right to health.

Demand is key to a working health system. Yet too often, as can be seen in the case of South Sudan in recent years, financing and policy focus on the supply-side factors. Where supply and demand are both starting from something close to zero, they need to be seen as 'co-evolving'. Fewer than 10% of women deliver in a health facility in South Sudan. Without doubt, there are traditional views of health and care in rural villages, and these may divert some health-seeking into local practices that are detrimental to good outcomes. But it is, perhaps too easy to blame 'tradition' or local 'culture' for what appears to be low uptake of modern health services. What appears to be weak demand may in reality be poor supply: inability by households to reach and access services, and disappointment with what they find on the occasions when they do.

This paper sets out six challenges that, together, should constitute priorities for action on healthcare and MNCH in South Sudan:

Challenge 1: The social context, determinants and barriers to demand for MNCH care are not, as yet, adequately understood in South Sudan. Investing in grounded research to comprehend these demand-side dynamics is critical to improving the potential impact of health policy, strategy and system building. But in addition to local drivers of MNCH thinking and behaviour, this paper argues that the way services are supplied is itself; a key determinant of community perceptions and demand for care.

Challenge 2a: Stronger investment is needed in the Primary Health Care Unit (PHCU) level, expanding its infrastructural capacity to supply facility-based basic obstetric and neonatal care. At present, the level of the health system physically most accessible to the majority population (the PHCU) is the weakest and least mandated to supply critical MNCH services. As currently structured, MNCH care relies on infrastructure, technology and skills being built at higher levels, including some Primary Health Care Centres (PHCU), but more often, in reality, it is focused on county, state and teaching facilities. Where pregnancies cannot be catered for at the Primary Health Care Unit (which is frequently the case), women and families are expected to pursue a referral process to often distant clinics. Constraints on transport and costs associated with referral as a whole act as disincentives to care-seeking, especially where the expectation of quality care is fairly poor.

Challenge 2b: A corollary to this is the need to increase qualified facility-based and better trained community-based health staff. There is a dearth of health professionals in South Sudan, and likely time lags in the important longer-term aim of tertiary training for in-country capacity. In view of this, there is an argument for building qualified capacity at the PHCU level (sourced locally where possible but internationally where not), providing core facility services, but simultaneously supporting and coordinating a more coherent, trained, supervised and appropriately incentivised community outreach health worker cadre. This approach would combine the humanitarian strength of international NGO partners (providing qualified micro-teams based at strategically-located PHCUs over the medium term) with the developmental imperative of building a systematised, locally-available, community-level health worker capability.

Challenge 3: National health policy, including the Health Sector Development Plan (HSDP), Basic Package of Health Services (BPHS), and Maternal, Newborn and Reproductive (MNRH) strategy, are comprehensive and ambitious. They are fitted for the long-term construction of a mature, universalist health system. If poor MNCH is to be addressed in the shorter-term though, greater focus is needed on interventions that make the greatest impact on the most acute problems. While infant and child mortality have improved over recent years, and are coming into line with regional neighbours, maternal and neonatal mortality in South Sudan remain stubbornly high and regionally exceptional.

To that end, national MNCH-oriented policy should focus on improving locally-available and accessible antenatal, intra-partum and immediate perinatal care. This includes promoting appropriate nutritional practices for mothers and their infants, contextualised by greater emphasis, through community outreach, on family planning and sexual health. This is in line with the Government of South Sudan's recent commitment to the UN Secretary General's Every Woman Every Child initiative which includes the provision of free reproductive health services, especially Emergency Obstetric care services⁵. This paper argues that ultimately, the strategic MNCH goals RoSS/MoH should be pursuing are: obstetric care at the point of childbirth, provided at the most accessible local level, contextualised by good neonatal care, with antenatal care and family planning delivered direct to communities, while scaling up and maintaining infant and child health interventions to expand on any gains.

³ Newborn mortality is 51 per 1,000 live births, infant mortality 84 per 1,000 live births, and for children under 5, 106 per 1000 live births.

⁴ Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966.

⁵ <http://www.everywomaneverychild.org/commitments/all-commitments/entry/11123>

Challenge 4: Better health data – systematically gathered, sufficiently granular to capture the realities of health needs at the local level, and publicly available – are vital to focusing policy on the right problems, and evaluating the effectiveness and cost-effectiveness of interventions. The development of a national health information system, and the periodic implementation of national census surveys are very positive moves in South Sudan, but need to be complemented by more localised, sentinel surveys of MNCH conditions, including quantitative analysis of health outcomes at payam and boma levels, as well as qualitative analysis of community conditions, perceptions of health need, and behaviour in MNCH care-seeking. INGOs and other actors engaged in project implementation are likely to have a substantial reserve of data, case studies and evaluations that should be brought together to form an MNCH evidence platform for dialogue around effectiveness and design, and use in collective advocacy.

Challenge 5: South Sudan has considerable resources available for spending on national priorities. Health – and the specific issues of MNCH – should be among the highest of these. For the present, 'hard' security (translating mainly into expenditure for security sector agencies and veterans' affairs) is pre-eminent in national budgeting. Developing the argument – as and where it can be based on solid empirical evidence – in favour of essential social services as a means to strengthen human and community and well as national security should be a shared aim among partners. At the same time, the donor community should continue to build on its impressive record in harmonisation – in particular looking to agree coherent common priorities and principles for health and MNCH in the forthcoming Health Pooled Fund – whilst avoiding the pitfalls of aid flow disruption resulting from a shift in institutional attention from a humanitarian to a developmental agenda. That shift may be based more on political and fiscal calculations at capitals, and an understandable national appetite to ensure sovereignty over external actors, than on the realities on the ground.

Challenge 6: International partners working with the government in South Sudan, especially in cases where they engage in policy dialogue, need a detailed and clear understanding of the institutions, imperatives and policy processes ongoing within the Republic itself. This would involve an analytical approach to key policy issues including the balance of priority between security and social spending, and the ways in which intersectoral coordination is being achieved across ministries within RoSS as a basis for action on the structural social determinants of health and MNCH. Given the dynamic pace of statebuilding in South Sudan, this kind of analysis is valuable not only in providing an understanding of current government thinking, but also in understanding how RoSS policy positions are likely to evolve over the medium and longer-term and how partners can support them.

Strategic options are available to RoSS/MoH and partners to aggressively attack the causes of poor maternal, newborn and child health in South Sudan. The question is whether those options will be taken up. Ultimately, action falls into two parts: on one hand, improving the underlying structural drivers of poor MNCH, in particular around the question of gender equity, addressing the social standing of girls and women, their education and their reproductive choices; on the other, and central to this paper, strengthening both supply of and demand for accessible and acceptable professional and trusted obstetric, antenatal and neonatal health services, close to communities, and embedded in wider community-based work to extend family planning, sexual health and MNCH education.

Priorities for MNCH Policy Advocacy and Action: short, medium and long-term objectives

Improving MNCH in South Sudan requires a wide range of actions to strengthen the determinants of effective healthcare. This matrix breaks down the six challenges set out in the main body of the report, suggesting ways in which priority actions can be organised according to that concept of sequencing.

	Short Term	Medium Term	Long Term
Demand	Field-based research showing demand-side barriers	Promote local/demand-side quantitative and qualitative analysis in MNCH policy/strategy reviews	Strengthen local civil society capacity to support community MNCH monitoring and reporting (see Data, below)
Healthcare access	Focus on strengthening PHCU and community-based Human Resource capacity	Build higher-level Human Resource capacity (county/state), through formal training	Support referral system with PHCU (primary), PHCC (secondary), county (tertiary)
Policy	Develop and promote an MNCH (MNRH) 'sub-strategy' using external comparator country studies	Promote constitutional commitment to 'equity' in RoSS/MoH planning/policy	Develop and support RoSS/MoH in adopting an 'equity gauge' for monitoring distribution of, access to and benefit from MNCH care
Data	Develop INGO MNCH knowledge/evidence 'platform'	Support collaborative multi-county MNCH and community perception surveys	Strengthen community-level independent civil society capacity in MNCH monitoring and reporting
	Engage with working group on methodology of MMR survey	Engage with HMIS design and roll-out	
Finance	Call HPF donor dialogue on evidence-based MNCH priorities	Promote RoSS commitment to Abuja Declaration	Strengthen RoSS/MoH stewardship role through joint contract performance assessments
Political economy analysis	Engage with donors and RoSS on aid transition plan	Block grant reform to ensure more equitable distribution of government funding for health services and MNCH	
	Initiate and sustain PEA engagement, consultation and analysis for South Sudan, welfare/security, and MNCH		



A World Vision community trained vaccinator helps immunise a child against measles.
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Introduction: South Sudan – Security, Development and Health

The broad facts of South Sudan are reasonably well-known: a newly-recognised country,⁶ emerging from two sustained periods of conflict over almost 50 years, operating under tense neighbour relations to the north; fiscally oil- and aid- dependent, predominantly rural, extensively poor.

South Sudan today reflects the combined effects of sustained conflict and collapse in already-minimal infrastructure, displacement and continuing flows of returnees, ongoing incidence of violence and insecurity, regional tensions, and widespread, chronic and acute ill-health, malnutrition and poverty. At the same time, its institutions of governance are strengthening, changing their historical relationship with external partners. This is not a scenario that fits easily into contemporary distinctions of humanitarian and development paradigm (ACF et al., 2011; Jooma, 2011; Frontier Economics, 2010; International Crisis Group, 2009).

According to available data, South Sudan has among the worst maternal, infant and child health statistics in the world. Reducing deaths during pregnancy and in the first years of life should be – and on paper is – a national priority, as outlined in the South Sudan Maternal, Neonatal and Reproductive Health Strategy⁷. The Government of South Sudan has further made a commitment to the provision of free reproductive health services, especially Emergency Obstetric care services, in their recent commitment to the UN Secretary General's Every Woman Every Child initiative⁸. The question is though, whether what exists on paper – in policies, strategies or research evidence – supports real, material improvements in the conditions that make childbirth in South Sudan a question of life and death.

With an estimated population of between 8.3 and 9.5 million population (including a large and growing population of internally displaced people and returnees), South Sudan has a total fertility rate of 4.6⁹ (with a national growth rate of around 3% (RoSS, 2010)). Teenage pregnancy is relatively high, at 200 births per 1,000 women age 15-19 (RoSS/MoH, 2009a).¹⁰ Maternal, neonatal, infant and child mortality in South Sudan are among – if not the – highest in the world (ACF et al., 2011; RoSS/MoH, 2010). Maternal mortality (MMR) is just above 2,000 per 100,000.¹¹ Neonatal mortality (NNMR) is 51 per 1,000 live births.¹² Infant mortality is 84 per 1,000. And child mortality is 106.¹³ Around one third of children are recorded moderate or severely underweight. While almost all children are registered as having some access to breastfeeding (94%), this falls substantially to under half in the 0-5 months range exclusively breastfed. Roughly one in eight children (12-23 months) has received immunisation for diphtheria, pertussis and tetanus and less than 2% of children are fully immunized.¹⁵

Malnutrition is a significant cause of poor MNCH in South Sudan. It is an underlying factor in about $\frac{1}{3}$ of deaths for children under five years and about $\frac{1}{5}$ of maternal deaths in developing countries¹⁶. Malnutrition also has a strong negative influence on early child growth and development in all contexts. In South Sudan, indicators

⁶ Following a referendum, independence was declared on the 9th of July 2011.

⁷ Southern Sudan Maternal, Neonatal and Reproductive Health Strategy: Action Plan 2008-11, Ministry of Health of Southern Sudan and UNFPA, 2007.

⁸ <http://www.everywomaneverychild.org/commitments/all-committments/entry/1/123>

⁹ According to the 2010 Sudan Household Health Survey (SHHS). In other literature, TFR is cited as high as 6.7.

¹⁰ This equates to 20%. Adolescent (15-19) pregnancy ranges from 2% in China to 18% in the Latin America and the Caribbean (WHO, 2011).

¹¹ At last measurement. The 2006 national census records an MMR of 2,053 (CI 95%); an inter-agency estimate, produced by WHO, Unicef, UNFPA and the World Bank in 2007, recorded an MMR of 2,045.

¹² According to the 2007 Situation Analysis of Reproductive Health and Adolescent Sexual and Reproductive Health in South Sudan. More recent figures from the 2010 Sudan Household Health Survey (SHHS) are not available.

¹³ According to the SHHS, 2010. These represent improvements on 2006, with IMR at 102/1,000 and CMR at 135/1,000.

¹⁵ Children aged 12-23 months receiving BCG, DPT 1-3, OPV 1-3 and measles vaccines before their first birthday. 2010 Sudan Household Health Survey.

¹⁶ Black et al. Maternal and Child Undernutrition I: "Maternal and child undernutrition: global and regional exposures and health consequences." The Lancet, Volume 371, Issue 9608, Pages 243 – 260.

for both acute and chronic child malnutrition are above desired thresholds indicated by the WHO. Around 12% of children have acute malnutrition,¹⁷ 25% are stunted and almost one third of children are recorded underweight.¹⁸ Underlying factors include issues around infant and young child feeding practices, periodic household food insecurity, and a poor health environment. Though malnutrition needs to be addressed through cross-sector development, especially in the sectors of hygiene/sanitation, livelihoods, and agriculture, about one third of the burden of malnutrition could be addressed by simple cost-effective interventions provided through an effective healthcare system that targets MNCH appropriately.

Access to – and use of – MNCH-related healthcare services in South Sudan is relatively very low. In 2010, a little over 25% of pregnant women received antenatal care from a skilled professional (though the formally recorded rate of access to at least one ANC consultation was reported at 48%). Only 1 in 10 deliveries was attended by a skilled professional. Over 80% of all deliveries happened at home, attended either by a traditional birth attendant (TBA) or by relatives. Prevalence of contraceptive use is very low, at around 3.5% (RoSS/MoH, 2010; Evans & Rehnstrom, 2010). Household availability of insecticide-treated nets is just 2%.¹⁹

Understanding and acting on health requires more than clinical interventions and pharmaceutical remedies. Real, long-lasting improvement comes from action on the social determinants of health – the conditions in which people are born, live, work and age. Attention to determinants such as gender inequity is the foundation of better MNCH in South Sudan's long-run future.

But mothers, children, families and their communities need help to reduce maternal and child mortality now. This imperative leads naturally to a focus on the health system.²⁰ This focus is supported by two observations. First, many of the most powerful interventions to improve maternal, neonatal and child health are to be found within the toolkit of basic healthcare services.²¹ Second, the healthcare system is itself, a key determinant of MNCH. As a set of institutions in which the state and the citizen engage with one another to negotiate national resource allocation to grassroots needs, the healthcare system is a microcosm of the wider system of social determinants. Ultimately, observing the interaction between people seeking healthcare and those providing it, offers a useful lens through which to gauge progress in wider systems of governance.

For all the challenges faced coming into 2012, South Sudan constitutes an opportunity for government and donors to think in new ways about how to foster development with security, how to combine stability with citizen wellbeing and within this, how to respond to the crisis of maternal, newborn and child health in households and communities across the country. Key to this will be development of a health system which shifts the focus towards investment at the local level, building an effective bridge between MNCH care demand and supply, between the lowest level facility of the health system and the community.²² It is likely this will require continuing and increasing investment in health human resource capacity – a 'surge' in more highly-skilled, locally-based MNCH specialists, providing facility-based services while coordinating and training a more coherent community health cadre.

Under foreseeable circumstances, that surge will require a significant continuing contribution from non-state actors primarily in the form of INGOs in the medium to longer term. On the basis of that argument, re-imagining the long-term relationship between government, donor and INGO (beyond the unrealistic expectations of handover to state ownership in the short-term) will be the measure of intelligent aid and effective national and local MNCH action in South Sudan.

¹⁷ WFP,VAM Food Security Analysis, South Sudan Food Security Monitoring, October 2011.

¹⁸ 2010 Sudan Household Health Survey.

¹⁹ ibid

²⁰ 'Health system' includes a wider set of actors than the more narrowly-constituted 'health sector'. A country's health system incorporates the skills, activities and contributions of government, civil society, and communities.

²¹ For example, improvement in basic capabilities for facility-based delivery integrated with community outreach to improve home-care practices for neonates.

²² Consistent with intervention models designed under the Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Newborn and Child Illnesses (IMNCI) models (WHO, 2011; UNICEF, 2011).

MNCH in South Sudan – why it matters

There are three principal arguments for focusing on MNCH – moral, economic, and security-related.

The moral argument: Maternal and child deaths in the poorest countries represent perhaps the greatest global health inequity²³ – partly because the gradient in inequality between richest and poorest worldwide is so grotesquely steep,²⁴ and because such a significant proportion of these deaths is avoidable. But also, perhaps, because, of all the conditions arising from the difference between poverty and wealth, the needless deaths of mothers and their children is the one that most directly offends a global consensus on our common human entitlements.

The International Covenant on Rights states that everyone has a right to the 'highest attainable standard of health'²⁵. As pregnant women and children are particularly vulnerable there is an argument for governments, as duty-bearers, to prioritise the realisation of the rights of women and children to good health. The Convention on the Rights of the Child further conveys a responsibility on the global community to support developing country governments to this progressive realisation of the right to health.

Furthermore, the international community has already committed itself to massively improving MNCH outcomes globally. More than a decade ago, 189 countries united in their commitment to the Millennium Development Goals (MDG), in which reducing maternal and child mortality were both recognised as distinct priorities. Progress has been made, in particular in reducing deaths among children under 5. Yet maternal and neonatal mortality remain, in many parts of the world, stubbornly high. Two-thirds of the way to the MDG deadline, donors and aid-recipient countries alike must recognise and act on these commitments.²⁶

Beyond the moral imperatives, action to improve MNCH makes economic and political sense – especially to governments attempting to escape the cycles of conflict and fragility. On one hand, improving maternal and child health can contribute substantially to economic growth. On the other, there is growing (if, at present only suggestive) evidence that improving public services, including those for health, can contribute to statebuilding and stability in countries coming out of conflict.²⁷

The economic argument: The strong positive correlation between health and economic growth is now widely acknowledged (Commission on Macroeconomics and Health, 2001). We see, for example, a strong positive association in China between growth in per capita GDP and reduction in maternal mortality (Yanqui et al., 2009). Conversely, there is a 'perfect negative correlation' between rates of child mortality and economic development in countries in sub-Saharan Africa (Ojong, 2009) – the higher the rate of child death, the lower the rate of economic growth.²⁸

For many years, analysis focused on the idea that better health is the result of increased wealth. But more recently, research has started to show how better health is actually a causal contributor to economic growth. Evidence suggests, for example, that there is an inverse step relationship between incidence of maternal mortality in Sub-Saharan Africa and countries' per capita GDP (Kirigia et al., 2005).²⁹ Estimates from the World Bank show that undernutrition contributes to an individual loss of 10% of lifetime earnings and reduced GDP by as much as 2-3%.³⁰ Current rates of maternal and newborn mortality (leaving aside infant and child deaths)

²³ "[M]aternal mortality is the world's worst health inequity." Deputy Secretary-General Asha-Rose Migiro (2009). Report of the Global Campaign for the Health Millennium Development Goals, 15 June, DSG/SM/462; DEV/2743.

²⁴ Chances of a woman dying in pregnancy are 1 in 31 in Africa; and 1 in 15,700 in Italy. Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. World Health Organization, Geneva 2010. <http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html>

²⁵ Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966.

²⁶ In its MNRH strategy document, RoSS/MoH makes the point very clearly that 'achieving the MDGs in South Sudan is impossible under current resource conditions' (RoSS/MoH, 2009).

²⁷ To the extent that 'fragility' is commonly defined in part as the incapacity or unwillingness of the state to provide basic services to its population, improvement in public services like health can be assumed to contribute to fragility reduction (see DFID, OECD, World Vision etc.).

²⁸ Worryingly, both from the point of view of South Sudan's dependence on oil revenues in unpredictable international markets, and volatility in aid, economic instability is associated with maternal, neonatal and infant mortality (Brenner, 1973).

are estimated to cost US\$15 billion in lost productivity globally each year (WHO, 2010).³¹ Investments in MNCH are then, investments in national economic development.

Moreover, providing basic treatments to address MNCH are cost-effective. It is calculated that, for some countries, every dollar invested in family planning saves four dollars in subsequent complicated and unplanned pregnancy treatment (WHO, 2010). But improving MNCH can have wider positive impacts on economic growth. According to the World Bank's Sector Director for Gender and Development, investing in women is "the right thing to do, but also smart economics".³² In Bangladesh for example,, maternal morbidity has been associated with diversion of up to 40% of household savings to out-of-pocket health costs, whilst reducing child mortality has been associated with some potentially highly productive changes in households' perception of children's value, and consequent behavioural shift towards investment in education.³³ Between '30% and 50% of Asia's economic growth between 1965 and 1990 has been attributed to reduced infant and child mortality, reduced fertility, and improved reproductive health' (WHO, 2010). Whatever the sovereign priorities of the state in South Sudan, investing in MNCH makes good economic sense.

The security argument: Health has for some time now been recognised as a major factor in international security and global stability (Chan & Lansley, 2011). Failed and fragile states can create powerful vectors for pandemic disease, as well as the transnationalisation of instability. The role of health – and of health services – in strengthening stability *within* countries is, for now, a more tentative proposition in empirical terms. However, donor countries such as the UK and the United States, as well as multilateral actors, are becoming more interested in the potential of public service provision to underpin political and economic processes of stabilisation, improving *both* national and human security (World Bank/MDTF, 2011;³⁴ USAID, 2011;³⁵ Lillywhite, 2009).

One comparative study of post-conflict recovery contrasts the relatively strong stabilisation and settlement processes in Bosnia Herzegovina and El Salvador with the slower and more uneven process seen in Sierra Leone (Filipov, 2006), associating the former with high levels of early investment in education and health services (Filipov, 2006). Filipov concludes: "education and public health are strongly linked to the political and economic stability of a country, and while international aid can establish an ephemeral stability, only better education and public health...can retain it." (*ibid.*).

It may be argued that there is, for the present little evidence of popular dissatisfaction with public services such as healthcare turning into opposition. Predominantly rural, often dispersed and remote communities may not have a strong sense of entitlement against which to gauge their disappointment; nor may they have the inter-community institutions through which to organise such opposition in their own right.

But three factors militate in favour of thinking about healthcare as a route to stability and security in South Sudan. First, the long northern border remains a highly sensitive region. Investment in better services here, especially among more remote communities, may reinforce social cohesion and stability from county, through to state level at Juba. Second, persisting economic and non-economic (e.g. asset, food security) poverty among rural communities have been shown to feed the growth of economic crime and competition among ethnic

²⁹ In other words, the deaths of mothers has a discernible downward impact on growth.'Maternal mortality of a single person was found to reduce per capita GDP by US\$0.36 per year.'

³⁰ World Bank. 2006. "Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action." Washington, DC: World Bank.

³¹ An analysis of 17 African countries showed that 'every dollar invested in family planning yields a return of between \$2 and \$7 (HandtoHand campaign, 2009).

³² <http://legacy.wilsoncenter.org/ondemand/index.cfm?fuseaction=home.play&mediaid=3379EF86-B08B-88F0-D2C099A59281B5CF> [accessed 19 November 2011].

³³ There is some evidence that as risk of child death declines, parents shift from valuing children as labour to valuing children as an investment by increasing access to education (Strulik, 2004; Kalemli-Ozcan, 2002).

³⁴ <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SUDANEXTN/EXTAFRMDTF/0,,contentMDK:21149630~menuPK:3226202~pagePK:64168445~piPK:64168309~theSitePK:2193668,0.html> [accessed 18 November 2011].

³⁵ "Other sources of grievance, such as weak service delivery, will likely continue to plague post-CPA South Sudan."

groups; they may also create a base for recruitment by emerging militant opposition (ICG, 2011). Third, high rates of returnees, largely from the North, many from Khartoum, bring with them experience of much better public services. Settling often in transit sites around major population centres (in Unity, Northern Bahr el Ghazal, Upper Nile, Warrap and Central Equatoria States³⁶), they have the potential to form an articulate, expectant and disappointed constituency much closer to the centres of government administration.

There is a growing body of analysis, including work in South Sudan, which holds some hope for improved services at the local level as a means to strengthen security by strengthening community-level support for government (Stewart & Brown, 2010; Narayan & Petesch, 2010; Eldon et al., 2008; OECD-DAC, 2008; Brinkerhoff, 2008; Newbrander, 2006). It is sometimes suggested that 'security' is the prerequisite to other kinds of action, including rehabilitation or development of essential social service systems. The consequence of that view is that security investments take priority over the restoration of basic services. But current and new thinking about the relationship between peacebuilding and statebuilding suggests that securing state legitimacy in the eyes of the population depends, in part, on popular perceptions of a concrete peace dividend.³⁷ In other words, the application of 'hard security' through military, peacekeeping, police and judiciary works in combination with, rather than as a discrete precursor to, 'soft security' measures such as visible and tangible improvement in the material circumstances of communities uncertain of the future and tired of the past.

"Effective programs that protect and strengthen the most vulnerable and reach the most remote and inaccessible areas are critical to both sustainability and stability"

International Dialogue on Peacebuilding and Statebuilding, OECD 2010

Several new research endeavours are now being rolled out to investigate aspects of the linkage between service provision, state legitimacy and security. South Sudan's are precisely the circumstances in which solid research of this kind is both valuable and necessary.

³⁶ These states are seeing a continuing flow of returnees according to WHO April-September 2011; Tearfund, 2011.

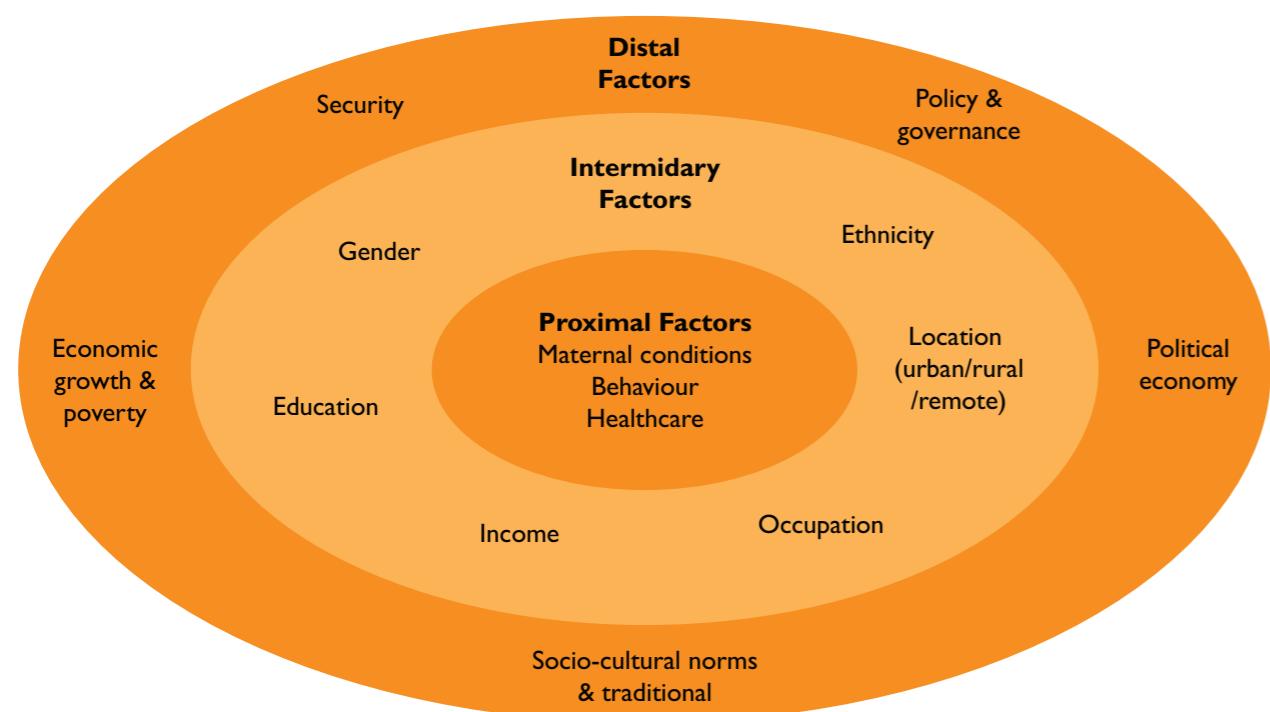
³⁷ See, e.g. DFID, 2010. This argument does not set aside the analyses of the World Bank (WDR, 2011) and OECD (Bennett et al., 2010). Clearly, 'citizen security' relies centrally on the creation of conditions – through force where necessary – of safety from harm for people in communities going about lawful daily business. Equally, the provision of basic services in itself does not get to the root of the causes of conflict in South Sudan. But improvement in vital basic conditions such as health is, this paper argues, a necessary corollary to investment in state security. Communities, it is suggested, are more likely to view continuing government support to military and security infrastructure as an acceptable condition of post-conflict governance if they see, alongside this, governmental concern for their own livelihood priorities.

Understanding the Roots of MNCH – a social determinants approach

The major determinants of health, and MNCH, lie in the social, political, economic and cultural arrangements by which a society organises itself (WHO, 2008).³⁸ At the local level (in the centre of the illustration in figure 1, below), people's health is determined by the material circumstances in which they live, and the behaviours they adopt.³⁹ Material circumstances and behaviours are, themselves, influenced by people's social status (in the mid-section of the illustration), including gender, ethnicity, education, occupation, income and place of residence.⁴⁰ And the effects of social status are, themselves, determined by society's wider values and governance (the outer ring).⁴¹

Healthcare is located in the central ring of the schematic. However, as we will argue in following sections, the way healthcare is accessed by households and communities (that is; the demand-side) is strongly determined by their material circumstances and social norms. Furthermore, the way healthcare is provided (the supply-side) is clearly determined by a country's governance and policy choices. In these respects, the health system provides a lens through which we can see the linkages – or the gap – between processes of state policy-making at the centre and delivery of vital services on the doorstep of a family at the periphery.

Figure 1: The Social Determinants of Health



³⁸ World Health Organisation (2008). Closing the Gap in a Generation: final report of the Commission on Social Determinants of Health, Geneva.

³⁹ Adapted from the social determinants of health conceptual framework of the Commission on Social Determinants of Health. The three interacting 'tiers' of health determinants are often described as 'distal' (deep-seated), 'intermediary' (or stratifying), and 'proximal' (material, behavioural genetic etc).

⁴⁰ A university-educated woman living in a city centre earning in the top part of the income range is likely to have much better health prospects than a similar woman with no schooling living in a remote village. But both of them are likely to have worse life chances across a range of measures than their husbands or brothers.

⁴¹ It is worth noting, of course, that as nations become more interconnected through processes of globalisation, increasingly strong influences are brought to bear on the outer ring of the schematic. As international agreements – in trade, aid, security and other domains – grow in number and strength, analytical care should be taken by those promoting such agreements to ensure that countries at a very early and fragile stage of national consolidation are not adversely impacted in ways that could flow through to worsening health outcomes at the local level or, indeed, wider forms of social ill such as economic downturn and intra-ethnic fragmentation.

Macro-drivers in South Sudan: insecurity, poverty, gender inequity

In any given country, different determinants will combine to play prominent roles in the production of population health. In South Sudan, three macro-level drivers of maternal, newborn and child health (from within the schematic above) are of particular prominence: first, the problem of security, coming out of an extended period of conflict; second, the prevalence of absolute poverty in the country and approaches to developing economic activity especially in the agricultural sector;⁴² and third, the scale of inequity in gender norms and relations.

The health consequences of conflict are well researched, with widely impoverished communities struggling to subsist, often with meagre access to even the simplest health-critical goods and services – from water and sanitation through to an active healthcare system (PLoS Medicine, 2011; World Bank, 2011; O'Hare & Southall, 2007; Palmer et al., 2006; Ronmans & Graham, 2006; Newbrander, 2006; Moreno Torres & Anderson, 2004).⁴³ Relations of gender inequality support maturation, marriage and childbearing processes that, without good clinical and care support, can be life-threatening – and not just once-off, but sustained throughout a woman's fertile years. The prevailing depth of poverty makes household finance for even the smallest expenditure, including health, a matter of critical decision-making and hard trade-offs.

There is a clear need to understand the dynamics of insecurity and poverty as they influence MNCH conditions in South Sudan. This could include small-scale research projects – to explore communities' perceptions of the relative benefits of security services and provision of other social services, such as health;⁴⁴ or to explore how communities currently use their generally very small reserves of cash money, and how, in this respect, small conditional cash payments to households might alter MNCH-related health-seeking behaviour.⁴⁵ But, while improving security and reducing poverty may feed over time into better maternal and child health, they are more indirect routes in which MNCH is only one objective and hence neither necessarily the strongest lever to push policy nor the only incentive in terms of results. Gender equity, however, forges a much stronger, clearer and more direct connection between macro-level institutional norms and conditions for mothers and children on the ground.

Gender inequity: addressing the early marriage issue

Gender inequity is one of the most powerful and intractable drivers of poor maternal, newborn and child health.⁴⁶ According to respondents who participated in the process of researching this report, it is one of the most significant determinants of MNCH in South Sudan. Economic institutions relating to dowry practice feed through into very early betrothal arrangements, early-teen marriage, early and multiple pregnancy which, along with harmful practices such as female genital mutilation bring associated health risks to mothers and infants. There is a marked absence of family planning (including very limited availability of female contraceptives and ostensibly strong cultural resistance among boys and men to male contraceptive use⁴⁷) and inattention to sexual health. These gaps, reinforced by a weak value cycle ascribed to girls, women, wives and mothers, expose women to repeated risk, whilst withholding decision-making power over options to mitigate such exposure, such as power over accessing basic services. At root, shifting household preference from dowry/marriage to extended girls' education is central to improving MNCH in South Sudan.

⁴² At an estimated 90% of the population (RoSS/MoH, 2010).

⁴³ It is important to note that poor health outcomes are by no means confined to situations of conflict or post-conflict. Nigeria, for example, has one of the worst rates of maternal mortality in the world (Shiffman & Okonofua, 2007).

⁴⁴ A survey in Greater Monrovia in 2009-10 found that households in even the most insecure areas of the city ranked electricity and health services above security sector strengthening in the overall scale of their aspirations for community security (AOAV, 2011). Rapid expansion of healthcare provision in South Africa after 1994 has been associated with the scale of popular confidence in government in the early period of the transition (World Bank, 2011).

⁴⁵ A policy laid out by the GoSS in the South Sudan Development Plan 2011-2013.

⁴⁶ '[W]omen's status, as measured by indicators such as level of education relative to men, age at first marriage, and reproductive autonomy, is a strong predictor of maternal mortality' (Shen & Williamson, 1999).

⁴⁷ In a primary school focus group discussion in Liet Nong, Warrap State, a boys' group discussed interventions to improve maternal health. Contraceptives were raised as a possible means. When asked if this meant condoms, the entire group shook their heads in uniform and emphatic disagreement.

In the long-term, this will involve changing the perception of value among household decision-makers, from girls as immediate means of wealth consolidation (dowry, marriage, children) to girls as providers of broader family welfare (education, safer motherhood, better child-rearing, greater wage employment opportunities). In the shorter-term however, a practical entry point to wider change in perceptions of gender is to advance marriage registration. Whilst this will be hard to roll out and enforce, with weak county-level administration and very high levels of rural illiteracy and innumeracy,⁴⁸ it could nonetheless, put the issue on a formal footing through national legislation, and establish a space for public awareness and dialogue, as the basis of gradual change in practice.

Healthcare: a key determinant of MNCH

Changing the macro (or distal) socio-structural drivers of health and MNCH takes time – more often measured in generations than in funding cycles. The conditions in South Sudan – combining humanitarian emergency and development process – are such that many stakeholders remain strongly interested in approaches to MNCH that offer a combination of relatively fast, as well as potentially long-term impact. Working through the healthcare system – changing the availability, accessibility and acceptability of healthcare services, not only through the supply-side, but through a better understanding of the determinants of MNCH service demand, offers a more immediate route towards lowering/decreasing maternal and child deaths.

Following that argument, this study concentrates on the structure and function of healthcare in South Sudan, arguing that the health system is itself a foundational driver of MNCH⁴⁹ (not least given the particular clinical requirements of, especially delivery and perinatal care). But arguing, further, that many deeper-seated social, economic and cultural drivers of health – which in sum reflect the governance between the government in Juba and its diverse population – can be seen working through the way healthcare is supplied, and the way it is experienced at community level.

Better healthcare has been a central feature of improving MNCH in a number of fragile and post-conflict countries, even where the wider context of social determinants remains challenging. Dramatic improvements in infant and under-5 mortality have been claimed for Afghanistan in the period from 2004-2008, despite entrenched levels of economic poverty. Access to BPHS services is estimated to have risen from 9% to 83% of the population (though the quality of these data may be an issue). Much of this is associated with improvement in the delivery of healthcare services; itself, linked to the localisation of health services access and the coordinated outreach role of community-based health workers (PLoS Medicine, 2011; USAID, 2007).

A major focus on healthcare, despite persistently poor living conditions resulting from the ongoing conflict in Beira City in Mozambique, saw results in falling child mortality during the 1980s (Cutts et al., 1996). Eight years on from its own comprehensive peace agreement, Liberia has seen significant reduction in child deaths, attributed to high-level political commitment to healthcare, and a substantial increase in health sector spending (World Vision, 2009).⁵⁰ Sri Lanka and Nepal have also both emerged from conflict with significant improvement in aspects of MNCH (Keith & Cadge, 2010). In the case of Nepal, the role of community health workers – and by implication, increasing the proximity of healthcare and community need – was associated with a fall of about 30% in overall child mortality, even in the absence of access to wider healthcare (Pandey et al., 1991).⁵¹

This report supports the role of community-level health workers, but not as a blanket prescription. CHWs work when they are trained, coordinated, supervised and properly valued. Training implies substantive commitment, rather than short-term courses, and requires both classroom and applied skills development. Supervision implies the need for professionally qualified personnel in regular contact with CHWs, and thus the positioning of qualified staff at the local level. CHW valorisation should consider appropriate statutory remuneration (such as salary) rather than incidental ‘emoluments and kind incentives’.

Building a healthcare system in South Sudan that comprehends local needs, builds local demand, and integrates delivery of priority interventions at facility and community levels, is the major route to better MNCH now and in the longer-term. The following section identifies 6 challenges to healthcare system development, and offers some observations on priorities for further research.

Designing Healthcare to Improve MNCH in South Sudan: six challenges

Almost all interviewees in Juba and Warrap agree on three core drivers of poor MNCH in South Sudan: infrastructure and human resources on the supply side, and community behaviour in terms of demand.⁵² A considerable proportion of MNCH-related policy development, investment, and action in South Sudan has focused on developing supply-side capacity (institutions, administration, training, and to some extent technology). Much less has been devoted to the demand-side – the recognition of and response to community needs by government, and the engagement by communities with MNCH-critical healthcare services.

Indeed, the questions of supply and demand are frequently treated as distinct categories of analysis. Yet, with both utilisation and provision of healthcare starting, for all intents and purposes, from zero in South Sudan, supply and demand should be understood as ‘co-evolving’; treating them as separate is inefficient.

A fourth – and arguably critical – driver of poor MNCH in South Sudan can then; be described as a ‘health governance gap’ – a structural disconnect within the healthcare system between government and partners’ health planning and policy, and the reality of health experiences and needs in communities.

This paper suggests that more attention should be paid to the demand-side of MNCH healthcare. But also that demand and supply factors should be viewed as interactional – recognising that the supply of healthcare for MNCH can itself be a powerful driver of demand, and should therefore be structured much more closely around community experiences, perceptions and understanding of maternal and child care. The remaining sections of this paper set out six priority challenges for MNCH in the structure and function of healthcare in South Sudan, starting with the issue of demand, and looking at how five key supply-side factors – access to care, policy, data and information, finance, and the political economy of health in South Sudan – can be developed to respond better to MNCH needs on the ground.

⁴⁸ Illiteracy is estimated to be as high as 80% among women and girls in South Sudan (Evans & Rehnstrom, 2010). To advance marriage and birth registration literacy classes could be provided to chiefs.

⁴⁹ WHO, 2008.

⁵⁰ The Rebuilding Basic Health Services programme in Liberia appears to have contributed significantly to improvements in health at least in part through an emphasis on coordinated service delivery through contracted NGOs, building their capacity to supply services on the ground.

⁵¹ Successful reductions in maternal and child mortality in other countries, like Iran, Cambodia, China and Indonesia, have also been associated with improved provision of healthcare services in the rural sector, using local capacities, with the development over time of an effective referral system from village community to higher level facilities (Yanqui et al., 2009; Taylor & Marandi, 2008).

⁵² As noted earlier; this is consistent with the three pillars of the IMCI strategy model.

Challenge I: 'Do they...don't they?' Understanding community demand for MNCH care

"Community awareness is a major problem; they do not understand modern healthcare"

UN Juba & Warrap State

Low demand for healthcare is cited unambiguously by respondents as one of the biggest drivers of poor MNCH in South Sudan. Yet understanding of, and explanations for low demand tend to be more opaque, often based on assumptions rather than solid evidence. What seems clear is that understanding community perceptions of MNCH, as a major driver of the demand-side dynamics of healthcare seeking in South Sudan, has not been a significant priority in official policy and strategy formation, and has only as yet attracted limited interest in terms of research.

The failure of large parts of the population to access and use healthcare services is often ascribed to a preference for alternate, 'traditional' care models. This preference, it is asserted, comes from a combination of ignorance (empirically captured as illiteracy but often subtly expanded to imply a wider inability to understand, value or engage with forms of 'modernity' such as the biomedical model), and 'cultural beliefs' (again, code for nominal systems such as 'witchcraft').

It may well be that significant parts of the country, or of certain ethnic groups, or of particular sub-regions and communities, subscribe to such alternate health beliefs and behaviours. But it may also be that the majority of communities, households, men, women and children, have a reasonably clear-eyed view of the health problems with which they grapple daily. This may be informed by a moderate but identifiably scientific/epidemiological approach to trying to understand disease causation and correspondingly, likely effective treatments. This would indicate a willingness to use modern health care to the extent that it is available in a way that allows for practical access and the expectation of effective results.⁵³

"The main problems for women are extended labour...infection...medicine for children after birth. We need doctors...drugs...microscopes...laboratory technicians"

Boma Chief, Gogrial West, Warrap State

It may well be that the root causes of what appears to be low demand for healthcare and MNCH services in South Sudan are to be found in the material obstacles that lie in the way of availability, accessibility, and acceptability: challenges of transport and user fees or shadow costing; perceived inability among women to take time away from childcare and other household chores; experience, and hence expectations of poor or negligible service at local health facilities; the regular disappointment of referral to implausibly distant higher healthcare centres, or costly local pharmacies. These may be significant drivers of demand for MNCH across communities. The reversion to a traditional birth attendant (TBA) or other localised 'healer', the citing of songs

⁵³ In 2010, World Vision commissioned an anthropological study that focused on infant and young child nutrition in the Dinka communities of Tonj South county. Findings showed that there are mixed beliefs pertaining to the causes of child malnutrition. Many believed that it is caused by a mother having sex while she is still breast feeding or ill will from a dead relative. Because of these issues, traditional treatment options were often employed to address child malnutrition before support from the nutrition programme was sought, often after malnutrition had progressed considerably. The study went on to find that as community based management of acute malnutrition (CMAM) became increasingly accessible through the health system infrastructure and was able to show its effectiveness as a means to treat child malnutrition, there was an increase in prompt care seeking when a child was malnourished. This indicates that quality care that is consistent and accessible will be valued by the community, and care seeking behaviours will improve, even if there are perceived alternative treatments.

and prayers and attaching of bead strings to sick mothers and infants, may not be simply the expression of a preference for the non-biomedical – rather these actions may be better understood as the increasingly fatalistic recognition that the services families *would like* are simply outside their reach. Too often, 'culture' is invoked as a kind of vernacular language to describe the behaviour of people whose reality is actually a straightforward lack of options.

The fact that communities, in research, may conjure a range of explanatory frameworks for illnesses they experience should not be taken to imply a literal belief in supernatural or at least empirically unfounded causation or cure. Rather, what is clear is that communities struggle, through whatever epistemological means are most familiar and easily to hand, to understand their health problems and determine optimal solutions. For communities engaged in this process to see modern healthcare as a significant option, the system has to be both present in their lives, and credible in its impact.

"We used to go to the forest for medicine, now we try the clinic first. We use traditional medicine if the clinic does not work."

Magai Women's Group, Gogrial West, Warrap State

Building a Demand-side Research Agenda for MNCH in South Sudan

Greater understanding of community MNCH demand requires more applied ground-level research. Two priority areas for such research recommend themselves. First, it is possible that the evidence of high levels of awareness of, and demand for, modern MNCH healthcare comes from communities situated relatively close to urban centres, transport routes and/or health projects.⁵⁴ Research could be designed to assess the level of awareness and demand for healthcare calibrated against the remoteness of communities. The hypothesis would be that increasing remoteness correlates with decreased awareness of modern MNCH healthcare options, and an increase in use of traditional medicines/practices. A potentially interesting outcome of this research would be a clearer sense of how remoteness mediates communities' orientation to modern and traditional healthcare models.⁵⁵ Additional research could look at how comparative information (on other livelihood-critical issues such as market prices for produce) circulates within payam and boma levels.⁵⁶

It is clear though that high levels of health information do not, on their own, reliably translate into a significant increase in healthcare demand, expressed, for example, through attendance at health facility. Distance between villages and health centres, potential costs, and low expectations of quality effective service have been raised as major barriers to demand, even where awareness is strong. However, attendance at a health facility is, in a sense, the end-stage of a process of thinking and decision-making much of which happens within the household and the village.

A second piece of research could be designed to capture and understand not just the range of material barriers that appear to mediate between village need and health centre supply, but also how decisions are made within households, and within wider community structure,⁵⁷ about when and under what circumstances to seek external support. Again, this could focus primarily on health, but could include comparative analysis of other conditions affecting households, such as food insecurity, or need for security and justice interventions.

⁵⁴ A common and problematic bias in project operations as well as field-based research, and a recognised potential weakness in the evidence base presented in the arguments of this scoping study.

⁵⁵ This also has a bearing on developing healthcare that fits with the perceptions and behaviours of mobile communities such as pastoralists.

⁵⁶ This research could be extended to explore how households value different cash commodities – on what, in other words, they are most willing to spend very scarce cash resources. This could provide useful insight into the relative value ascribed to health expenditure, as an element within the wider household and village economy.

⁵⁷ Including the range of influencing actors from neighbours and TBAs through village chiefs, faith leaders, pharmacy owners, boma executive chiefs amongst others. But also looking beyond the conventional field of stakeholders to explore other less well-recognised sources of information and advice.

An intriguing insight into the demand side of MNCH came up in village and TBA interviews – that complications in pregnancy were largely unknown during the period of conflict, and have arisen in the period after the peace. These findings are preliminary, based on a very limited set of interviews. But they point to the possibility that communities associate increased risk in pregnancy and childbirth now, with the establishment and extension of a formal healthcare system. They certainly suggest that communities monitor MNCH conditions among their own households, and are engaged with seeking possible causes and solutions. This analysis supports the idea that improving community perceptions of the quality and accessibility of healthcare can strengthen the tendency of households to value and seek out such care.

“Before, during the conflict, pregnancies were not difficult. Difficulties have come up in the period after the war.”

Traditional Birth Attendants Group, Gogrial East, Warrap State

Health and MNCH policy, planning and supply-side development appear to be carried out in South Sudan around a central absence of information about the dynamics of MNCH demand. Research interventions such as those set out above would aim to fill what is a glaring gap in the evidence-for-policy framework, answering a series of core questions: What are the perceived health priorities at household level, and where do MNCH issues fit within that ranking? How is information about MNCH acquired in the community, and how are MNCH-related decisions made within households and within the village hierarchy? What is the political economy of health knowledge and expertise within the village community setting? How are scarce household resources devoted to welfare spending, and what are the indications that spending on health constitutes a priority? How do material conditions and previous experiences of poor supply affect the nature of MNCH care demand among men and women in households? To what extent do households and communities associate the quality of health services in their local experience with wider perceptions of governance?

Below: Dinka women hard at work. © Arthur Mist/World Vision



Challenge 2: Improving Access to Care

“Can you bring the hospital closer to our village?”

Liet Nong Primary School Girls' Focus Group, Gogrial East, Warrap State

Traditional approaches to healthcare system development which focus on building out from urban and administrative centres ‘are not likely to be effective or efficient’ in providing services to those whose needs are greatest – dispersed rural communities in remote areas (WHO, 2001). This is particularly important in the case of MNCH, where maternal and child mortality increase proportionally with the increased remoteness of communities (Bartlett et al., 2005; Macassa et al., 2003). Community distance from health facilities has been found to be one of the major barriers to providing emergency obstetric and neonatal care services in other Sub-Saharan African countries (Gabrysch et al., 2011; Admasu et al., 2011).⁵⁸

Yet, from the CPA forward, much international and government attention has been concentrated on building capacity at the centre, with ‘far less attention...at state, county and payam levels’ (Tearfund, 2011; ICG, 2011).⁵⁹ Investment in more highly qualified health personnel (an increasing number of whom are being recruited from neighbouring countries) and comprehensive and basic emergency obstetric and neonatal care are channelled mainly to state hospitals, county health departments, and Primary Health Care Centres.

Below PHCC level, attention seems to taper off. The RoSS/MoH Health Sector Development Plan (2011-15) talks about ‘hospitals’ and ‘PHCCs’, with only one reference to the Primary Health Care Unit level. PHCUs are the most local level of the healthcare system, and represent the closest point of contact between the administration and the community in matters of health. Yet they remain, for the time being, rudimentary both in terms of staffing and service delivery capacity. For example, in the 2010 Health Sector Development Plan, 74% of operating cost budget is allocated to PHCCs, county facilities and hospitals, while just 6% is allocated to PCHUs (RoSS/MoH, 2010).

Investing in the Local: the PHCU and its communities

PHCUs are caught in a vicious circle. Poorly qualified (or entirely absent) staff at PHCU level justify government stipulations limiting quite severely the kinds of services that can be delivered at that level. Perceptions of poor staffing (as well as shortage of equipment and drug stock-outs), and consequent limits on available services justify communities’ decisions not to seek care.⁶⁰ Breaking this circle will require simultaneous investment in the PHCU – and critically in the staff deployed to this level – with much stronger community outreach.

In the current configuration, MNCH demand (for antenatal care, obstetric intervention, neonatal cover, management of childhood illnesses and malnutrition etc.) is expected to flow upwards from the community, first to the PHCU but, where services cannot be offered at this level, through a referral system to higher (more distant, potentially more costly) levels of the healthcare system. Right now, between six- and nine-tenths of population demand for healthcare services in South Sudan is lost between the community and the PHCU (RoSS/MoH, 2009).

“Post-partum haemorrhage can take 2 hours to kill. Most referral takes a lot longer than 2 hours.”

RoSS/MoH, Juba

⁵⁸ And in the wider sense of healthcare and security, concentrating resources on ‘previously deprived groups in the rural and poor areas of the country’ has been suggested as a priority strategy for building state-citizen cohesion at the fragile margins of new or conflict-recovering nations (Narayan & Petesch, 2010; Filipov, 2006; Newbrander, 2006).

⁵⁹ It is worth keeping in mind the potential collective memory of highly centralised systems of policy and service development from the pre-CPA/independence period could itself feed through into tensions within the South Sudan administration. If South Sudan, as an emerging nation, seeks to distinguish its future from that past, better, more decentralised systems of service delivery would be a strong starting point.

⁶⁰ Moreover, the better qualified the health personnel, the less willing they are in many instances, to accept a remote or ‘low-level’ posting.

Roads in South Sudan are extremely difficult to traverse, especially in the rainy season. The majority of health facilities are located on or near to major roadways for obvious reasons but this means that a significant proportion of villages are relatively remote from even the most local facilities. The average distance from village to nearest facility (e.g. PHCU) is 22km (DFID, 2009); the average distance from village to higher-level facility (e.g. PHCC) is 120km.⁶¹ Private and public transportation is extremely limited, and comes at a cost which, however small, may discourage households working with minimal amounts of cash money. From a demand perspective, where villagers do not have confidence in the services they will receive at the PHCU, there is very little incentive for them to expend any resources on making an often arduous journey. Building community confidence in the PHCU is the first step in a properly demand-driven healthcare system.

Investing in the Local: solving the human resource question

One of the most prominently cited drivers of poor MNCH in South Sudan is the absence of qualified health workers, in particular those with skills in midwifery and obstetrics (Pearson, 2010; Buor & Bream, 2004).⁶² The human resource deficit is most acute at PHCU level (*ibid.*). RoSS/MoH strategy to improve health human resources focuses on professional training for existing and new cadres, and creation of new cadres at relatively higher levels of qualification. Complementing this, partners are exploring options both to bring in external, qualified cadres, and to send South Sudanese personnel to study in countries with more established training facilities (such as Kenya, Uganda and Tanzania).

These are important strategies. But they raise questions of timeliness and sustainability at the level of much-needed local impact. Training facilities will take some time to rehabilitate and standardise (Beesley, 2009), along with limits on (especially female) student numbers and a 2-3 year lag in study time. Cross-border recruits meanwhile, are mostly being posted at national and state levels, with limited evidence of a trickle-down effect on capacity. Policy thinking appears to marginalise the local level of healthcare throughout. Most PHCU staff drawing a salary are paid by INGOs. Very few PHCUs have a plan for hand-over to the government (DFID, 2011).

Training and professionalisation of a national health worker capability works both in the medium and long-term. Developing a functional referral system between lower and higher levels within the healthcare system, equally, reflects a solid medium/long-term strategy. In the short-term however, investment in people and skills integrating PHCU and community-based service delivery is vital.

A PHCU strategy could be designed in two parts: first, by strengthening the professional quality of PHCU staff; second, by rationalising, formalising, coordinating – and paying – a more clearly structured community health worker cadre.

In the first case, INGOs could agree to collaborate in offering to provide a much larger number of more highly skilled health professionals (from whichever sources they can access, but arguably necessarily in many instances internationals), to create skilled 'micro-teams' at selected PHCUs (and PHCC) in each county. These teams (possibly comprising a qualified doctor and midwife or equivalent) could be posted for 2-3 years, building provision of basic obstetric services at the PHCU facility level, and coordinating and supervising the MNCH outreach activities of the community cadre.

⁶¹ Additional disincentive to demand can be created by cost. Whilst the Interim Constitution clearly states that basic health services should be provided free at the point of use, it is concerning that the 2011 health facility audit found just over a third of facilities charging some kind of user fee. In addition to formal charging, the costs of transport can be compounded in the case of antenatal, delivery and neonatal care by the requirement on households to furnish various items associated with care, such as soap, sheets and food. Further costs can be added where facilities refer to village pharmacies to procure medicines.

⁶² There are a total of 14,667 health workers in South Sudan. Over a quarter of these are 'higher cadres' (doctors, nurses, midwives and clinical officers) (RoSS/MoH, 2011). As with health facilities, per capita distribution of health personnel is uneven across the country, ranging from 1 doctor to 11,377 people in Central Equatoria to 1 per 195,267 in Unity State.

In order to address the second case, it is necessary to rationalise the bewildering array of community-based or outreach health worker cadres in operation in South Sudan. There is already some planning within RoSS/MoH to standardise some or most of these cadres into 'home health promoters' (HHP). This is a positive sign. However, key issues need to be addressed in strengthening the community-level health cadre. First, the precise parameters of what the community cadre can and cannot do should be agreed and set out clearly.⁶³ The role of the community cadre would need to be carefully developed, to provide basic services and preventative health and nutrition messages at village level, to encourage confidence in healthcare seeking by households, and to channel that healthcare seeking towards a better-equipped and more capable PHCU. But it is critical to ensure that the community cadre does not perceive itself to be, or allow communities to perceive it as, an alternative or adequate substitute for care provided through the formal system. This is an important observation with respect to the future of TBAs.

After several decades of commitment to the value of TBAs in the early stages of health system formation, there is now debate over the degree to which TBAs can contribute to improving MNCH, and indeed the extent to which they may actually increase the risk of poor outcomes for mothers in particular (Harrison, 2011; Ana, 2011). It appears there is a balance to be struck between positive and negative TBA attributes. On the negative side, TBAs are frequently untrained, illiterate and – crucially – fairly heavily invested in relations of trust in their communities founded on practices which are sub-standard in terms of diagnostics, treatment selection, and hygiene. These practices can be extremely hard to shift, especially where TBAs themselves are unable or unwilling to acknowledge the limit of their own capabilities. On the positive side, TBAs are the most locally available, locally-embedded health resource with specific mandate in MNCH. They are characteristically well-known (and often well-respected) to their constituencies, and on-hand for information and advice as well as treatment.⁶⁴

The key to the future of TBAs in South Sudan for better MNCH lies in building on and maximising the utility of their positive value, while limiting their role where it can be detrimental. In this respect, a major role for TBA development should be that of community-based health 'counsellor' – building on the well-evidenced levels of local recognition and trust, but limiting the extent of community-based diagnosis and treatment. Although RoSS/MoH policy expresses some ambivalence towards TBAs, there may well be willingness to find ways to retain the value they offer. In any case, it seems clear that TBAs cannot simply be disbanded and dismissed. Rather, they could be incorporated into the community level health cadre – possibly in a supervisory role (where others potentially less entrenched in questionable practices could be trained into community service delivery, while TBAs themselves would be moved into a lateral role of community mediation and oversight).

A PHCU strategy of this kind raises serious questions of cost, and may be seen as flying in the face of conventional notions of national ownership. With INGOs working at the margins of available resources, and RoSS ministries engaging actively with the question of how, over time, to substitute international for national capacity, a short/medium-term 'surge' approach to local HR capacity is likely to raise some eyebrows. But it offers a clearer route towards greater MNCH impact in a meaningful timeframe. A PHCU-centred model of this kind combines the humanitarian principle of high-impact localised delivery irrespective of source (the micro-team), with the developmental principle of in-country capacity building (community health outreach cadre), leaving behind, at the end of three years, a strong, clinically field-tested, locally-trusted health service capacity. As a model, it challenges the assumption that humanitarian programming in some sense necessarily undermines or goes around host state and society, showing how, when brought together under a theory of change, in a meaningful timeframe, active service delivery and capacity to deliver work hand in hand.

⁶³ The community cadre could provide basic materials/treatments such as vitamin A and iron, contraceptives, oral rehydration therapy, bed-nets etc. However, the scope of treatment mandate would need to be clearly circumscribed, to avoid misuse of sensitive drugs (such as antibiotics). The community cadre could also provide sustained ongoing dialogue with households around issues of family planning, birth spacing, sexual health and nutrition, see *Policy*.

⁶⁴ The concept of the 'traditional' is, itself, an ambiguous and double-edged one in international development and inter-cultural studies. In terms of MNCH, traditional practices constitute, on one hand, indigenous systems of knowledge and trust supporting communities' capacity to manage their own lives. On the other, 'traditional practices' are included as a matter of concern and indeed proscription in international human rights negotiations (see, e.g. the 2nd UN Regional Seminar on Traditional Practices Affecting the Health of Women and Children, Colombo, Sri Lanka, 4-8 July 1994 (E/CN.4/Sub.2/1994/10/Add.1 and Corr.1)).

Challenge 3: Focusing Policy on Impact and Equity

Health policy in South Sudan centres on the Basic Package of Health Services (BPHS). The majority of respondents (across government, donor and INGO) felt that the basic service package policy is, at the very least, ambitious, attempting to incorporate the full spectrum of services and capacities one would expect from a mature and well-funded health system. Arguably it therefore fails to focus on priority interventions that should command attention and available resources in the intermediate term. The same can be said of the national Maternal, Newborn and Reproductive Health (MNRH) policy and strategy (in final draft at the time of this report), which aspires to provide the full range of services in the MNCH continuum of care.

"Yes, the BPHS model is ambitious. Donors are looking for priority interventions, with stronger emphasis on outcomes"

Donor, Juba

An overarching strategic vision is important for setting and pursuing top-line goals (Keith & Cadge, 2010). However, it is necessary to balance long-term institutional strengthening with shorter-term supply of goods and services that create tangible change in people's lives in a timeframe that is meaningful to families and communities (Rumunu, 2011; Eldon et al., 2008). To achieve realistic MNCH improvements in the short term, RoSS/MoH policy needs to focus investment, within the MNCH 'continuum of care', on priority interventions that are targeted at, and measured against, attacking the primary causes of maternal and neonatal death.⁶⁵

Focusing on delivery and neonates

Infant and under-5 mortality have been improving in South Sudan since 2006. This may be associated with a degree of improvement in wider social determinants (such as nutrition, water and sanitation, and immunisation) in some areas. But there is concern that maternal and neonatal mortality have not improved at the same rate.⁶⁶ While South Sudan's infant and child mortality rates are starting to approximate those of neighbouring countries, maternal mortality is four times the rate in Kenya and Uganda, and neonatal mortality is almost 40% higher (RoSS/MoH, 2010).

The majority of maternal deaths are the result of difficulties which 'cluster around labour, delivery and immediate post-partum period, with obstetric haemorrhage being the main medical cause of death' (Ronmans & Graham, 2006). There is wide agreement now that the overwhelming priority in MNCH policy and practice should be given to investment in an intrapartum strategy 'delivered at primary level institutions, with referral' (Rai et al., 2011; Bhutta et al., 2010; Powell-Jackson et al., 2006; Campbell & Graham, 2006).⁶⁷ There is evidence to suggest that improving immediate post-partum, perinatal and neonatal care can reduce overall infant and child mortality. Approximately 50% of infant mortality occurs at delivery or within the first week of life. There is reasonable evidence that focusing on immediate perinatal care can produce significant improvement in survival.⁶⁸

⁶⁵This paper argues that for better outcomes in the most acute areas of maternal and child death, more policy and practice emphasis is needed on localised care for women in delivery, and newborns. This is not meant, in any sense, to downplay the importance of wider interventions – in nutrition, in particular, but also, of course, in building better systems for child care up to age 5, including improving immunisation rates from current low levels. It is simply the case that, if there is a common concern for maternal and neonatal mortality, there must be common agreement on the allocation of adequate, properly focused resources to the problem.

⁶⁶Bearing in mind the absence of maternal mortality for the 2010 survey. Neonatal mortality has been, according to some respondents, a lesser focus in practice within MNCH strategy (Cousens et al., 2011).

⁶⁷A strategy to save mothers' lives has substantial positive follow-on impact in the mortality and well-being of children. Children left motherless at birth are 3-10 times more likely to die before their second birthday <http://www.columbia.edu/itc/hs/pubhealth/modules/reproductiveHealth/mortality.html>

⁶⁸In one study, training in Essential Newborn Care among trained Traditional Birth Attendants (TBA) resulted in a reduction in stillbirths to a level equivalent to that of physician attended deliveries. This may be the result of trained TBAs improving their ability to distinguish between true stillbirths (where no resuscitation is attempted) and neonates suffering from anoxia or asphyxia (where resuscitation can be effective). Neonatal mortality has been shown to reduce where birth attendants have been trained in resuscitation techniques (Carlo et al., 2010).

There is a strong argument that a clear sub-strategy, within the MNRH policy framework, targeting maternal and neonatal mortality could make a real difference to MNCH in South Sudan. A sub-strategy of this kind would work through improved local facility intervention, contextualised by stronger community delivery of antenatal care, and continuous community delivery of family planning and reproductive health services (currently negligible in health sector budgeting).

Building equity in MNCH from the start

Following Article 35 of the Interim Constitution of the Republic of South Sudan, the current MNRH policy and strategy (RoSS/MoH, 2009) commit to '[e]nsuring universal access while targeting MNRH services at the most marginalized, vulnerable, disadvantaged and minority segments of the population.' (ibid). Yet in real terms, the country's MNRH policy emphasises technical capacity development over equity and community-level delivery. In the short-term, RoSS/MoH policy focuses on scaling up MNRH facilities and services in 'all existing hospitals and health centres', with additional investment in new facilities to be built under the 'accelerated healthcare infrastructural development programme'. The lower level of health facilities is largely overlooked. Priority will only, according to the policy, be given to more remote communities ('geographical areas where no health services exist, populations living in underserved areas, pastoral communities') in the 'medium- to long-term'. Supporting the argument made earlier in this paper on access to care, improving equity in health policy and strategy should be an urgent priority, not an aspiration left to the longer-run future.

"The health system is in a formative stage...For now the focus is on technology, not on social determinants"

RoSS/MoH, Juba

While the MNRH policy states that its approach offers a 'continuum of services to reach those in need through programmes that span the home, the community, the primary health unit, the primary health centre, and the hospital', county hospitals are identified as the 'primary referral site [for obstetric care]', with state and teaching hospitals as secondary and tertiary referral sites respectively.⁶⁹ As we have seen, the proportion of community MNCH need that reaches the county level is, in many cases, vanishingly small.

Moreover, only 'mid-level cadres' are authorised under the policy to provide essential obstetric services. With few mid-level cadres (almost by definition) present below the PHCC, MNRH policy actively suppresses the development of obstetric care at the lower level of the PHCU.⁷⁰ Yet obstetric care at the point of childbirth, provided at the most accessible local level, contextualised by good neonatal care, by antenatal care and family planning delivered direct to communities, are precisely the strategic priorities that RoSS/MoH MNRH policy should be promoting. This would likely involve shifting the tasking categories for levels of health workers, to allow for more delivery of basic emergency obstetric and neonatal care at PHCU level.

South Sudan's overarching health policy is well-constructed. The adoption of a basic package of services policy and strategy has seen significant positive impact in other contexts (Afghanistan, Liberia). In the long term, building universality, equity and comprehensive service are important markers of success in a health system. Evidence suggests that a more focused policy and strategy, emphasising interventions on four key issues (maternal and neonatal mortality, antenatal care, and family planning) could yield more concentrated results in the shorter term. One approach to the development of such a focused MNCH strategy would be to conduct a comparative review of health policy structure and MNCH performance in other fragile contexts where a BPHS model has been applied – in particular, Afghanistan and Liberia.

⁶⁹It is possible that international partners (bilateral donors, UN agencies) have encouraged this, whether knowingly or otherwise. One bilateral donor is providing almost \$20m a year over five years to develop Comprehensive EmONC in 8 state hospitals, while WHO supports obstetrician and nurse capacity at the same level.

⁷⁰The budget allocations set out in the MNRH policy (2009-12) reinforce the sense of a preference for technical capacity development over local capacity and equitable delivery, with around \$17m allocated over three years to recruiting and training health staff outside South Sudan, and \$135,000 allocated to recruitment of local midwives.

Challenge 4: Strengthening Locally-sensitive Data

"[A]ssistance provided to South Sudan over the past six years has been characterised by an absence of realism....an absence of accurate assessments and a lack of understanding of the situation on the ground"

INGO

Evidence – data – is often the poor cousin in social services programming. It can be seen as hyper-technical, obscure, and detached from the pressing needs of real people. In truth, of course, evidence, based on robust, verifiable data, lies at the heart of good healthcare and better MNCH.

Good data is fundamental to improving health. But it also reflects a wider level of progress in structural drivers of health. It underpins governance, through the verifiable accountability of all stakeholders including government, donors, NGOs and levels of operation with the healthcare system (Newbrander, 2006). It underpins appropriate and equitable policy-making, through channelling investments where need is greatest (WHO, 2008). And it underpins efficient action, through the selection of demonstrably effective interventions, monitored for performance against both process and outcome indicators (that is, whether services were provided as planned and whether, as a result, rates of targeted morbidity and mortality improved) (HSFN, 2009).

Data and information about health in South Sudan are extremely weak. Measures are already in place to address the situation. A national Health Management Information System (HMIS) is under construction, drawing together district information systems into a single, unified apparatus.⁷¹ One major potential weakness in the proposed HMIS though, is the system's reliance on computerisation of data at county level. Below that level, data management is paper-based, and reflective only of cases seen and logged at a health facility. With use of health facilities running at 0.2-0.4 visits per person per year (in other words, where a maximum of forty per cent of cases actually reaching any level of health facility), between 60% and 80% of data on community-level MNCH conditions will be lost.

Supporting the national health information system

A national Maternal Mortality Survey is planned for 2012 (since MMR was omitted from the 2010 SHHS). National census and health surveys are scheduled on a 5-yearly basis. To complement them, regular health facility audits are planned. Data related to child malnutrition is a valuable way to loosely track the nutritional status of a community and warn of spikes in food insecurity and well as indicate broader health. Data from CMAM/CTC programmes, nutrition screening, and/or growth monitoring projects should be included with primary health care statistics in a comprehensive HMIS. Establishing a sustainable national health information system is an extremely positive move, as is the 2012 MMR survey. But these approaches to data take time to develop and, at least initially, can lack local sensitivity. Regular, time-sensitive data showing what is happening in MNCH at the local level, month by month, are liable to remain under-represented or lost altogether. This is a problem, since it is through the presentation of high-quality data from the grassroots that policy-makers can be shown, through more granular trend analysis, where conditions are improving and where they are not, for MNCH policy to be able to respond.⁷²

"Some donors and aid mechanisms have focused much more on process indicators, and less on actual maternal and child outcomes"

Joint Aid Mechanism, Juba

Equally, absent or inadequate local level data make comparative assessment of MNCH interventions (in order to determine and invest in the most cost-effective) extremely difficult. Such data are key to the MoH's capacity to fulfil its 'stewardship' role over service delivery which, realistically, may continue to be led by partners for the foreseeable future (Soeters et al., 2011). In Afghanistan, it has been challenging to confirm apparent evidence of positive results in health sector reconstruction due to weaknesses in national M&E capacity (ADB et al., 2009).

Gathering local level data

The HMIS is a medium/long-term proposition. While it is being built up and operationalised, there is a clear need, in the more immediate term, to continue building the local picture. One strategy that could help to achieve this is the development and implementation of a series of small-scale household surveys on MNCH conditions (in a selection of counties across the 10 states). The survey design could pick up process indicators in terms of service delivery, but would match these against MNCH outcomes at the local level. A 'sentinel' group of county-level surveys could be designed by one agency, or as a collaboration among organisations working at the payam and boma levels, and could be repeated on a yearly or two-yearly basis as an independent MNCH 'health check'.

Alongside improvement in sub-county quantitative and qualitative data on MNCH, there is an opportunity to strengthen local civil society for community-based MNCH monitoring and reporting. This would involve mapping and supporting local civil society actors with concern for (or mandate over) local health conditions to provide community-level input on a regular basis to the County Health Department and other health service providers. Two examples of potential candidates are boma chiefs (via their monthly county-level meeting) and, where feasible, local women's self-help associations.⁷³

"We can help, but we are not getting any support from outside."

Women Can Do It self-help women's association, Kwajok, Warrap State

Building a platform of grounded MNCH evidence

There is already a growing body of in-country operational research and implementation experience, including a valuable resource of qualitative data available from international NGOs and UN agencies operating in the country. These agencies currently provide the majority of health services on the ground in South Sudan, including those targeting maternal, newborn and child health

As a short-term research priority, there is an opportunity for INGOs to work collaboratively to create an open-access platform, or clearing house, in which all MNCH materials – independent research projects, situation assessments, project designs, data from monitoring and evaluation – could be brought together and pooled.⁷⁴ This would provide several distinct benefits for partners: first, a pool of experience in MNCH issues and the efficacy of interventions; second, a common space in which to discuss and debate research methods and analysis, as well as different project designs, leading to more empirically robust consensus on MNCH priorities; third, following these, a pool of knowledge supporting collective and more powerful policy dialogue on strengthening MNCH investments with donors and RoSS/MoH itself.

⁷¹ It is understood that this system will supersede others that have to date been supported by various donors.

⁷² "...[I]t was important to get an accurate measurement so that we could make the policy decisions in response. So we went down to the village level and gathered comprehensive statistics on pregnancies, birth attendants at clinics, safe delivery, infant survival and other factors". Deputy Secretary-General Asha-Rose Migiro (2009). Report of the Global Campaign for the Health Millennium Development Goals, 15 June, DSG/SM/462; DEV/2743.

⁷³ This is speculative for the present. It is not clear how many such associations there are. Several were in evidence in Kwajok, Warrap State. Moreover, INGO engagement with local South Sudanese civil society (especially where actors are not constituted according to INGO organisational standards) remains somewhat weak.

⁷⁴ This would, at the same time, support the Ministry of Finance and Economic Planning's proposal to increase transparency in the aid sector by establishing a database of all projects ongoing in South Sudan.

Challenge 5: Focusing Aid and Increasing National Spending

The major financial resources in the Republic of South Sudan are official development assistance (ODA) and national revenue (the latter estimated, for 2011, at around \$5.67bn).⁷⁵ Within the 2011 national budget, over 98% (\$5.55bn) is oil-derived, with under 2% (\$110m) from non-oil sources. Potential oil wealth puts South Sudan in a slightly unusual situation vis à vis relative influence of external finance and in-country income in directing national policy priorities. Donors may find themselves more than usually confined to sectoral and 'technical advice' in the absence of capacity for more 'muscular' policy dialogue. This suggests that they need to ensure that their technical influence is coherent, and that it carries within it higher-level political objectives, such as pushing equity in services as a means of reducing risk of conflict resurgence.

Aid: smoother flow, realistic timeframe, common priorities

It is difficult to gauge aid flows to South Sudan. However, for the present, donor commitment appears strong.⁷⁶ Cross-donor harmonisation, in accordance with the Paris Declaration and Accra Agenda, has been a major focus, largely via the five principal fund-pooling mechanisms.⁷⁷ But many of these mechanisms have, at the same time, been criticised for sluggishness in bureaucratic process, leading to limits on efficient and timely disbursement; a somewhat unwieldy split in emphasis between higher-level institution and capacity building and largely INGO-channelled service delivery; and a limited amount of attention to health outcomes as opposed to supply-side performance.⁷⁸

Avoiding volatility in prospective aid flows is important as a general principle, but has a particular salience in health and MNCH in fragile contexts, where such volatility is associated with worse outcomes in child mortality (Marie Stopes International, 2011; Keith & Cadge, 2010; Wolf, 2007; Bokhari, Gottret & Gai, 2005).⁷⁹ More broadly, avoiding sudden and disruptive changes in the aid envelope as a whole is important in maintaining early wins in structural and service delivery terms. In this light, the expectation among donors and RoSS of a substantive shift from humanitarian to developmental phase in South Sudan is misconceived, and more reflective of donor comfort zones than realities on the ground.

According to a number of respondents, many parts of South Sudan are still in the early stages of post-conflict recovery. To create a deliberate break in funding modalities at this point, to the exclusion of direct service delivery programmes, would be inappropriate and, it can be argued, unnecessary. Without doubt, extending average grant period from 6-12 months to 2-3 years is sensible, but is probably not enough to capitalise on achievements to date. Longer grant periods (preferably at 3 years or more as standard), should be married with more creative combinations of delivery and capacity strengthening.

"2012 is going to be a messy year. Hopefully things will get better after that."

INGO, Juba

Extension of humanitarian funding beyond the nominal recovery period supported continuing progress in health system reconstruction in Afghanistan and Liberia (Canavan et al., 2008). Service providers should engage with donors and RoSS as early as possible, to establish a longer-term timeframe for the role of aid in developing the health sector and bringing down the rate of death among mothers and children. However that longer-term timeframe does not need to be predicated on a swift process of 'handover' from donor/INGO to RoSS. The current structure of MoH stewardship, contracting out to independent health service providers, used in a variety of other country contexts, is a solid concept for building health system and services.⁸⁰ This does not necessarily require reversion or transfer to direct national management in the short or medium term, as conventions of sustainability and ownership imply (ADB et al., 2009). However, for the long-term, government and donors need to form a much closer level of scrutiny over contracts and delivery, with particular emphasis on capacity development (Soeters et al., 2011). Government must occupy a visible position of public responsibility and (in particular budgetary) accountability for basic services and their impact in peoples' lives.

In the short-term, donors should be encouraged to be more specific in their commitment to funding MNCH. The establishment of the DFID-led Health Pooled Fund (HPF) provides an opportunity for that engagement to happen. Donors and service providers, possibly through a 2012 process of public policy dialogue, could work towards greater coherence, both in terms of the types of progress measures used for MNCH (including health outcomes as well as service access indicators), and in terms of agreement around prioritising evidence-based interventions for MNCH (Vergeer et al, 2009). In addition to agreeing common priority interventions, the HPF partners need to establish consensus on the fiscal basics of their engagement with health and MNCH in South Sudan. This may include, for example setting a nominal threshold for optimum per capita health spending.⁸¹

The proposed 2-state pilot on performance-based funding (PBF) led by the World Bank, appears to be aiming towards a per capita health spend of around US\$4.5. This is considerably lower than current contractor-led spending (US\$14-20 per capita per year), and much lower than spending targets set out in the Ross MoH Health Sector Development Plan (between US\$34 and US\$50 pc/pa by 2015). Whilst there should be little objection to evidence-generating trials of this kind, they should be designed according to commonly agreed principles (for example the absolute proscription, consistent with South Sudan's Interim Constitution, of health service user fees), and preferably organised in a comparative way, so that alternate models can be assessed in parallel. From an MNCH perspective, it is important to note for example, that a trial of PBF in the Democratic Republic of Congo found better rates of facility-based childbirth in the control group than in the PBF group (possibly associated with the absence of fees in control health centres, and the higher levels of investment in those centres coming from NGO contractors).⁸²

⁷⁵ It is difficult to determine precise amounts of ODA provided to South Sudan given the recent declaration of independence and ongoing restructuring by donors. In comparative terms, most recent figures from OECD-DAC show Sudan as a whole receiving around \$2.29bn total ODA, compared with just over \$6bn for Afghanistan. In per capita terms, Afghanistan received \$206 ODA per head of population, while Sudan received \$68. In a sense however, South Sudan represents an 'ideal confluence' of donors interests – on one hand, increasingly vocal commitment to maternal and child health among major bilaterals; on the other, concern for the global incidence of state fragility, the impact of violence and conflict on development investments, and the problem of insecurity, including putative spread of instability.

⁷⁶ The Multi-Donor Trust Fund (MDTF) is the principal partnership mechanism between donors and RoSS, administered by the World Bank. The Basic Services Fund is led by DFID. The Common Humanitarian Fund and the Sudan Recovery Fund are administered by UNDP. There is also the Capacity-Building Trust Fund. OECD-DAC, 2010 cites seven pooled funds.

⁷⁸ Although it should be noted that the Basic Services Fund has been commended for its flexible approach to disbursement, and its support to operationalising projects on the ground. This is an important observation in terms both of the design of new funding mechanisms (such as the Health Pooled Fund), and making sure good practices ongoing are not lost in the bridging from current to future aid delivery systems.

⁷⁹ Development assistance for health (DAH) to South Sudan fell from US\$214.8m to US\$169m between 2009-10.

⁸⁰ There is a growing argument in favour of contracting health service provision to independent actors, including INGOs. Contracting out has shown some positive results (relative to direct government provision of services) both for efficiency and equity, in Cambodia and Afghanistan. Evidence in Rwanda may be somewhat more debatable. However, in principle, a sustainable model of health service delivery in South Sudan could involve the development of a comprehensive network of long-term contracting agents (INGOs and others depending on evidence of cost-to-objective health outcomes). That said, contracting out, both for quality of services and equity of supply, requires a relatively strong regulatory role for government at Juba, state and county level. Community perception of the state providing more than simply 'light-touch' regulation may be important in building public approval for the RoSS model of governance more widely.

⁸¹ Achieving coherent, common priorities may well include piloting intervention models to assess effectiveness and cost-effectiveness. Such piloting, though, should be carried out in such a way as to enable clear comparison between alternative approaches (for example, the relative merits of contracting out health services compared with development of government-run service provision, and the relative viability of private sector actors vs public sector human resource development). Equally, attention to piloting in selected counties should not detract from activity and investment in non-pilot counties.

⁸² Other research shows that, in Afghanistan, government-run health facilities are able to provide services on par with centres contracted out to NGOs; in Liberia, Guatemala and Cambodia, the operational value of contracting out was found to depend on the pre-existence of a functioning healthcare system – which is substantially not the case in South Sudan.

Increasing the national spending for MNCH

Government financing for health increased rapidly following the CPA.⁸³ In the last couple of years however, government allocation to health has actually fallen as a proportion of national spending (from around 7.9% to 4.2% of total budget (RoSS, 2010)). Although the RoSS/MoH Health Sector Development Plan projects a rise in national health spending to something between 7% and 10% of total budget expenditure before 2015, this still falls short of the 15% set out in the Abuja Declaration. In the immediate term, RoSS should be encouraged to commit to and publish a road map towards achieving the Abuja Declaration. A key issue here is the wider question of MNCH and health as priorities relative to other major concerns at the level of central government in South Sudan. This question is dealt with in the next section, *Political Economy of MNCH*.

In addition to ensuring stable long-term development assistance for health, clear and coherent MNCH priorities, and a rising or stable level of health spending in national income, a medium/longer-term objective of MNCH policy dialogue should be to reform the fiduciary relationship between Juba and the states, though recognising that this is a long-term goal with quite complex political and technical dimensions.⁸⁴ At the moment, financial transfers between centre and states (and counties) take the form of a standard block grant. This does not reflect demographic difference between states or differential levels of need. As such, it distorts rational allocation of finance, leading to some areas with significant shortfalls in health funding. This sustains a justification among states for resisting political, administrative and technical accountability, and builds the underlying sense at state level of inequity in national resource management, with potential political consequences.⁸⁵

Challenge 6: Understanding the Imperatives of Security, Development & Health in South Sudan

“Spending on security will start to go down when the peace process is complete.”

RoSS, Warrap

Key to the success of relationships in humanitarian and post-conflict recovery processes is the ability and willingness of external partners to understand in detail, the priorities and imperatives of national governments. The development of this understanding is based on close, regular engagement and consultation, and the development of an accurate picture of the country's political economy.

According to South Sudan's national development plan and budget in 2011, primary health care was the third-highest priority after security and roads. We have already addressed the question of whether that priority is realistically reflected in sectoral budgeting, but more broadly, notwithstanding positive trends, social spending remains dwarfed by spending in security.⁸⁶ Budget allocations to Internal Affairs and SSAF/Veteran Affairs for the current year, amount to just over US\$2bn. All security-related spending amounts to closer to US\$2.5bn, or 40-45% of total national budget⁸⁷, compared with a current level of around 4.6% for spending in health.

It is not unlikely that the Government of South Sudan will continue to perceive a significant and real threat to its security with cross-border tensions, and periodic internal disturbances, and that the budget will continue to reflect this to an extent. RoSS may, equally, take the view that continuing heavy investment in the security sector is a surer route to national security and stability than investments in improving local conditions – and perceptions – of services and welfare. Understanding, in some detail, the dynamics of the security-welfare balance within RoSS is critical to the capacity of international partners to engage intelligently and credibly with government on matters of competing priority, especially if there is a desire to engage in dialogue around the current fiscal calculus of security and social service provision.

“Don’t forget, the threat RoSS is facing is not imaginary, it’s very real.”

Donor, Juba

There is some evidence to suggest that multiple parties to post-conflict peace can advance social welfare priorities whilst, for example maintaining their military capacity. The perceived necessity of maintaining popular support through competitive policy agendas can make provision of social services, including health, an attractive political discourse in public policy, especially where elections are in the offing.

This is not in the main, the situation in South Sudan. The overarching governmental preference, right now, appears to be for substantial support to the military, security and internal affairs wings of the political system. Research that explores alternative models of security and stability – including the potential contribution of improved local basic services – could be of considerable use in extending the evidence-based space for policy dialogue around the balance of interests in security and investment in social services. This kind of political economy analysis would draw together the larger questions of the ‘external’ CPA-based political settlement, with more sector-specific questions of ‘internal’ developmental prioritisation within RoSS's vision for South Sudan.

⁸³ \$5.4m in 2006, falling to \$2.6m in 2007, rising sharply to \$109m in 2008, \$93m in 2009, \$132m in 2010 (outturn), and \$216m in 2011.

⁸⁴ And quite possibly an area of advocacy most appropriately led by donors.

⁸⁵ Although there are considerable risks in attempting to shift from centralised and standardised sub-national fiscal transfers, where ‘losers’ in redistribution may feel unfairly treated (Shah, 2003), there are complementary and perhaps more pressing risks in maintaining a too-closely controlled federal system of standardised block grant administration, especially where this can be seen to be inequitable when compared with different levels of poverty and need within the country. Nigeria and Pakistan are good examples of this problem (Suberu, 2001).

⁸⁶ Given the pressing need for more health personnel to staff the health system in a way which makes delivery of life-saving treatments possible, it is notable that Juba pays \$56.8m a year for Internal Affairs staff at state level, and \$9.4m for health staff.

⁸⁷ This is consistent with respondents' estimates during interview.

RoSS – at national and sub-national levels – may be expected to continue to evolve systems of governance. In this sense, political analysis should be designed as an interactive process of communication and engagement with senior government officials. The value of this kind of a political economy mapping lies as much in its analysis of how the landscape of governance is liable to change over the next 3-5 years, as in a static view of how things stand today. In particular, political economy could explore how systems of accountability are emerging in South Sudan, both through technical approaches to the use of data to enhance public transparency, and through the analysis of how multiple national and local actors are able to engage in policy design and assessment. This might include prospects for plural political groupings, but should also actively seek out existing and potential constituencies and capabilities within civil society.

A full-spectrum approach to improving health – and health equity – in South Sudan will require strong coordination for whole-of-government, intersectoral action. Changes to the health system set out in this paper, as well as changes in the macro-drivers of poor MNCH, will require close coordination among political and sectoral leaders. This will include the Ministries of Gender, Humanitarian Affairs, Labour, Roads, Transport, Education, Agriculture, Internal Affairs, and Finance. A second stream of Political Economy Analysis could, then, explore the ways in which ministries and sectoral specialists within RoSS are engaging with one another; how common priorities are established and how competing or even contradictory policy trajectories can be reconciled. Understanding how RoSS itself organises policy dialogue, budget allocation and legislative agenda is crucial to finding entry points for a progressive and mutually-understanding dialogue between international actors and government on MNCH.

Below: Young mother in a cattle camp. © Arthur Mist/World Vision



Conclusion

The challenges of security, stability and sustainable development facing South Sudan are daunting. The sheer scale of multiple needs across distinct sectors makes prioritising an unenviable task. But scarce resources need to be apportioned and some issues will inevitably take precedence. This paper argues that maternal, newborn and child health should be one of those issues.

The paper has presented a determinant's view of maternal, newborn and child health in South Sudan. It has focused on health care as the technical and social system through which MNCH can most directly be addressed at its most acute points – namely, local-level facility-based interventions to improve survival through delivery and among neonates, contextualised by community-based outreach through strengthened family planning and reproductive health.

This paper has chosen to focus on maternal, reproductive and neonatal health rather than the health of children beyond the neonatal age. This is in line with the distinction Government of South Sudan has chosen to adopt with its MNRH specific strategy. This should not be interpreted as due to a lack of need to address child health. Whilst recognising the importance of promoting the uptake of services and practices to prevent and treat childhood illnesses, it is argued that maternal, reproductive and neonatal health has received insufficient attention and should be further resourced and prioritised.

The emphasis on health systems is not intended in any way to detract from the long-term goal of changing deep structural drivers of poor MNCH, including gender inequity which flows through into both greater exposure to risk among girls and women, and less power to determine a safer reproductive pathway. However, the health system in South Sudan represents a kind of governance space in which technical interventions intersect with social attitudes, with policy as an expression of accountability between state and citizen. In that sense, the health system constitutes a perfect confluence of humanitarian protection, statebuilding, and sustainable institutional development – concentrated on the life chances of women, infants and children.

The paper identifies six challenges to improving the health system for MNCH. The grid below is intended as a summary of those challenges, with some indication of the timeframe in which action on them might be expected to achieve impact over the short, medium and long terms.

When discussing social, economic and human development, timeframes are more often than not arbitrary and, from time to time, more than a little specious. That said, the principle of this table is in essence, to urge a longer-term framing and better sequencing for MNCH interventions in South Sudan, linking the desire for effects in the immediate future with the need for sustained levels of policy attention and grounded intervention.

For the purposes of practical discussions that may flow from these challenges, 'short term' refers to action in the immediate 6-12 month period; 'medium term' refers to action in the first 3-year period; and 'long term' refers to action in the coming 5-year period and beyond. Timeframes relate to the order in which priorities should be taken on, rather than to an expected speed of impact. Indeed, impact from short-term priorities would be expected to continue through the medium and long term, while long-term impacts, where properly sustainable, would reasonably be expected to be open-ended.

	Short Term	Medium Term	Long Term
Demand	Field-based research showing demand-side barriers	Promote local/demand-side quantitative and qualitative analysis in MNCH policy/ strategy reviews	Strengthen local civil society capacity to support community MNCH monitoring and reporting (see Data, below)
Healthcare access	Focus on strengthening PHCU and community-based HR capacity	Build higher-level HR capacity (county/state), through formal training	Support referral system with PHCU (primary), PHCC (secondary), county (tertiary)
Policy	Develop and promote an MNCH (MNRH) 'sub-strategy' using external comparator country studies	Promote constitutional commitment to 'equity' in RoSS/MoH planning/policy	Develop and support RoSS/MoH in adopting an 'equity gauge' for monitoring distribution of, access to and benefit from MNCH care
Data	Develop INGO MNCH knowledge/evidence 'platform'	Support collaborative multi-county MNCH and community perception surveys	Strengthen community-level independent civil society capacity in MNCH monitoring and reporting
	Engage with working group on methodology of MMR survey	Engage with HMIS design and roll-out	
Finance	Call HPF donor dialogue on evidence-based MNCH priorities	Promote RoSS commitment to Abuja Declaration	Strengthen RoSS/MoH stewardship role through joint contract performance assessments
	Engage with donors and RoSS on aid transition plan	Block grant reform to ensure more equitable distribution of government funding for health services and MNCH	
Political economy analysis	Initiate and sustain PEA engagement, consultation and analysis for South Sudan, welfare/security, and MNCH		

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Annex I: Terms of Reference (August 2011)

Background and Proposition

The world's newest nation, South Sudan, has some of the world's worst health indicators. Infant mortality rate is 102 per 1,000 live births, under-five mortality is 135 per 1,000 live births and maternal mortality is 2,054 per 100,000 live births – making it the highest in the world.⁸⁸ The health challenges faced are significant.

With the Government of South Sudan's (GOSS) new Development Plan 2011-2013, a soon to be finalised Health Strategy from the Ministry of Health and scaling up of funding from donors for MNCH work following the 2010 G8 Muskoka Initiative, there is also real potential to increase impact and accelerate progress towards MDGs 4 and 5.

To contribute to this end, going forward World Vision South Sudan (WVSS) will be focusing its policy work on MNCH. Researching and analysing WV's extensive health programming to improve MNCH policy and practice at local, national and international levels.

Objectives

The proposed scoping study should help ensure that WVSS' policy on MNCH has:

1. Clear focus and added value: What are the key policy issues that WV should seek to engage on under the theme of improving MNCH in South Sudan, taking into account gaps in policy and practice, GOSS' and other stakeholders' (i.e. donor and multilateral) priorities, World Vision's work on MNCH and the community voice.
2. Clear relevance: What are the current and upcoming opportunities for influence in South Sudan through which engagement on the identified issues can achieve maximum outcomes.
3. Appropriate partners and targets: Who are the stakeholders that WVSS should be working to partner with or influence, at the local, state and national levels.

The scoping study should assess the policy, planning and resource landscape for MNCH in South Sudan and identify areas and opportunities to influence the content and delivery of these for improved MNCH outcomes. Specifically this work will assess 4 main questions:

1. What are the main drivers of poor MNCH in South Sudan? The consultant will identify the key social, cultural, political and economic factors that influence MNCH and assess key interconnections.
2. What are the key gaps in knowledge around the drivers of poor MNCH in South Sudan? The consultant should identify key gaps in existing research and make recommendations for areas for further research.
3. What aspects within the field of MNCH should WV focus its engagement strategy on in South Sudan? The consultant will make recommendations about where WV is best placed to focus its engagement activities. This will be based upon WV's programmatic strengths, national strategy and areas of recognised expertise.
4. Who are the key stakeholders that WV's engagement strategy needs to influence? The consultant should conduct a stakeholder assessment to identify the key stakeholders that WV's engagement strategy should target, and contribute to an understanding on what messages will most resonate with them.

This will entail conducting:

1. Desk research looking at existing MNCH research reports and government, donor and implementing agency strategies, policies and practices in South Sudan and other similar fragile contexts.
2. Field research to Juba and WV's health programmes in South Sudan. This will include meeting with communities, field staff, all levels of government, donors, UN agencies, NGOs and CSOs.

Annex 2: South Sudan Meetings, Interviews, Group Discussions

10-21 October, 2011

Juba

Ministry of Health
WHO
UNICEF
UNDP
UNFPA
DFID
CIDA
Basic Services Fund
World Vision South Sudan (Health and Nutrition, Advocacy)
PSI
Medair
International HIV/AIDS Alliance - South Sudan

Warrap State

WVSS (Gogrial West)
SMoH
Warrap DG-PHC
WHO Focal Point
Gogrial West County Health Office
Kwajok PHCC (Gogrial West)
Kuajok returnees focus group discussion (FGD)
Warrap State Secretary, RRC
Pariang Primary School, Gogrial West (FGD, girls & boys groups)
'Women Can Do It' Women's Association, Kwajok (FGD)
Magai Village (women's FGD)
Magai TBAs (FGD)
Magai Payam Chief
WVSS (Gogrial East)
Gogrial East County Headquarters/Acting Executive Director
Liet Nom Primary School (FGD, girls & boys groups)
Liet Nom PHCC

⁸⁸ Sudan Household Health Survey, 2006.

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