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Policy Brief

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Investing in Human Capital: Putting our Money Behind Our Words

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Summary

This analysis illustrates the Government of South Sudan's (GoSS) investment in basic services, especially health. It assesses planned government spending as a barometer of national priorities, focusing on the 2014-2015 fiscal year. The focus is on social accountability or justice—the need to ensure that South Sudanese have access to basic needs, including food, good health, and education. In doing so, the review does not touch on actual disbursements or expenditure, the planning, and implementation of projects or financial accountability. Our main findings from budget appraisals indicate limited investments in health per preplanned priorities, suggesting increased health spending for improved health outcomes in South Sudan.

Introduction

In 1987 African Ministers of Health launched the Bamako Initiative, vowing to accelerate access to health by strengthening primary health care service delivery, and prioritizing maternal and child health. The overall goal was a progressive realization of universal access to essential and quality health services as a means of improving health outcomes and overall quality of life. This was followed by the 2001 Abuja Declaration, in which African Heads of State pledged to allocate at least 15% of their annual budget[1] to improve the health sector, to accomplish the goals of Bamako and for the realization of the Millennium Development Goals set in 2000. The at least 15% allocation was established as a guideline for African Union member countries, in recognition that lack of progress in achieving health targets is a result of scarcity in health financing, but most importantly, "the Abuja Declaration made it clear that words were not enough. To truly transform the continent's future, African nations needed to take decisive action[i]."

[1] This 15% is in addition to the 0.7% of Gross National Income (GNI) pledged by donor countries as Official Development Assistance (ODA) to the developing countries).

Despite these pledges, adequate health financing remains a fundamental problem in Africa as a whole and in South Sudan, in particular. The World Health Organization (WHO) estimates that countries need to spend at least 61USD per capita on health in order to achieve Millennium Development Goals (MDG) targets for health[ii] and for some African countries, a 15% allocation does not meet the WHO guideline. As of July 2013, only Six AU Member States (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) have succeeded in allocating at least 15% of total government expenditure to health.[iii] Of these countries, Rwanda, Malawi, Liberia (prior to the Ebola epidemic) and Zambia have made significant progress toward attaining the MDG targets for health, implying an association between rational health care financing and health outcomes.

The analysis that follows illustrates the Government of South Sudan's (GoSS) investment in basic services. This review assesses planned government spending as a barometer of national priorities, focusing on the 2014-2015 fiscal year. Its primary focus is on social accountability or justice—the need to ensure that South Sudanese have access to basic needs, including food, good health, and education. In doing so, the review does not touch on actual disbursements or expenditure, the planning, and implementation of projects or financial accountability.

Health Conditions and Spending in South Sudan

South Sudan has the highest maternal mortality ratio (MMR) in the world, at 2054 deaths per 100,000 live births, and some of the poorest indicators on infant and child health, with mortality rates as high as 84 and 105 per 1000 live births, respectively[iv]. Only 46% of women go for the first antenatal care visit, out of which 30% are seen by a skilled provider. Fifteen percent of births are attended by a skilled healthcare professional and less than 25% of the population has access to healthcare.

South Sudanese politicians often speak of a commitment to improving the health of men, women and children, but in the 2014-15 national budget, this commitment to health translates to a paltry 3.5% of the Total Government Planned Expenditure (TGPE)[v] (see Table 1 below). Using the already low 2008 population census as a reference, South Sudan's total government spending on health is less than 14 USD[2] per person. The South Sudan Health Sector Development Plan (HSDP) 2011-2015 recommended at least 7% of the TGPE be allocated to health, and estimated that implementation of the HSDP would require 5.1 Billion South Sudanese Pounds (SSP) over the 5-year period. To date, total government spending for health is estimated to have been ~1.2 Billion SSP between 2011-2014. As we develop the follow-on 2015-2020 HSDP; the 2011-2015 HSDP has not been fully implemented.

[2] Assumes an exchange rate of 3SSP: 1USD)

While South Sudan is fortunate because the international community has committed to considerably contributing to financing health programs across the country, it is wise to note that the 15% allocation for health (Abuja) was not inclusive of, but in addition to donor funding. Given the poor health indicators and health infrastructure we inherited as a result of the war, and the deliberate neglect by the Khartoum government of the periphery, one of our key development objectives must be to increase per capita spending on health beyond Abuja[3]. Our words must translate into action.

Improving Health Outcomes: It takes a Workforce!

A minimum distribution of 2.3 health workers (doctors, nurses and midwives) per 1000 population[vi] is recommended to deliver essential maternal and child health services, and to improve health outcomes in general. The health sector in South Sudan faces a critical shortage of qualified and equipped health-workers. Many of the existing health workers were trained years ago during the war, and have had few opportunities to upgrade their skills since. The 2010 Health Facility Mapping estimated that South Sudan has 1,522 medical officers, registered and certified nurses and clinical officers, translating to a ratio of 0.18 of these cadres per 1000. Total number of all human resources for health was estimated at 3,946 with a 2015 target of 8,045 established in order to implement the Basic Package of Health Services (BPHS).

With adult literacy of 27%[vii] our key priorities in developing human resources for health must also include strengthening basic education at the primary, secondary, adult and tertiary levels, and in particular, accelerated training of the nurse-midwife cadre and teachers. While South Sudan may close the human resource gaps by hiring health workers from the region, it is more sustainable to increase the number of locally trained health workers. To achieve enrolment targets, there is a need to increase the number and quality of students graduating from primary and secondary schools. Currently, total enrollment in primary education, regardless of age is 69%, with a mere 10% primary completion rate. 64% of children aged 6-11 are out of school (SHHS 2010). We must significantly increase the percentage of children graduating from schools nationally and encourage especially girls to pursue careers in the health and education sector. This is only possible if we are committed to increasing the number and quality of trained teachers, and the number of health training institutions. As noted in the HSDP, "Out of the existing 36 pre-service Health Training Schools only 23 are functional and these mostly train low professional cadres." Health training institutions remain understaffed and insufficiently funded.

We promised that education would be our post-referendum dividend, but note that the

[3] The modest funds allocated for health are mostly for salaries and a great portion of these get wasted through mismanagement, leaving the donor communmity to pay for facilities, equipment, medicines and training.

current commitment to educating the children of South Sudan is a mere 5.6% of government expenditure; this is inadequate. Compare this to the 7.1% apportioned to police (twice the investment in health), or 3.44% to prisons and the priorities appear to be policing and/or imprisoning our citizenry. Our words do not translate into action.

Improving Health Outcomes: Nutrition

There is a recognition that malnutrition contributes to poor educational, maternal, infant and child health outcomes. The 2010 SHHS estimates the prevalence of moderate and severe stunting (chronic malnutrition) and wasting (acute malnutrition) to be 25% and 20.9% respectively. And while we speak of agriculture as the cornerstone of efforts to diversify the South Sudanese economy and to reduce overreliance on food imports and food aid, we devote a meager 0.7% (77.4 million SSP) to agriculture. With most of these disbursements expended on salaries and operating costs, very little remains for capital and sector-specific infrastructural enhancements or investment, making it difficult to develop the agricultural sector, and guarantee food security for the majority of the population. Contrast this to the 2% allocated to the Office of the President and the 1% to the fire brigade and there is urgent need to reconsider our financing priorities. All this gives an impression that social and humanitarian affairs, women and children, agriculture, infrastructure, reconstruction and development are peripheral to political affairs, the executive, the police and prisons, and the military. This is not the message we want to send to our citizens or our friends.

Conclusion

The most important resource in any country is its people. The utmost potential for sustained economic growth in the future is contingent on investing in human and organizational capital today. Developing the capacity to compete in this global economy means engaging the youth, strengthening health systems, guaranteeing food security and alleviating poverty, in addition to protection, rule of law, and defense. Seventy-two percent of the population is below the age of 30 (2008 census), and yet only 0.3% of total spending is availed for culture, youth and sports, and 0.13% for gender, child and social welfare. While one might justify allotting 37% of the national budget on security and an additional 14% on the rule of law (progress cannot occur amidst instability) this does not signify overlooking human resource development.

Whilst we remain poor, hungry and maltreated, it will be difficult to meaningfully contribute to the reconstruction and development of this nation. Abject poverty contributes to endemic violence. As we enter a period of forced austerity due to lowered revenues from the oil sector, this will necessitate reducing current rates of spending. It will be wise not to take the shortsighted viewpoint and further downgrade spending on social, welfare and economic issues. It will be imprudent to focus only on today and to forget that investing in health, nutrition, and education is inextricably linked with economic growth and poverty reduction, and is also synonymous with peace and

stability. One of the measures of a successful country is the quality of life of the majority of its people. As the New Year begins, let us take a minute to think about the living conditions of the majority of our people. Hopefully this will remind us of our obligation to improve the status of all South Sudanese as enshrined in our liberation manifesto.

Recommendations

In summary, improving South Sudanese living conditions may begin with:

- Reallocating resources with high priority given to social capital and infrastructure development.
- Increased spending on health to at least 15% of Total Government Expenditure annually. This will allow the MoH to fully implement the 2010-2015 Health Sector Development Plan.
- Training and graduating large numbers of mid-level health providers yearly, with priority given to the dual nurse-midwife cadre and establishing retention programs to ensure that health workers are rationally distributed nationwide. An estimated 8,000-12,000 skilled health providers are needed.
- Strengthening education at the primary and secondary levels to ensure students are well prepared for higher education and are able to compete regionally and internationally. This requires accelerated training and deployment of qualified teachers and construction and rehabilitation of schools nationwide and
- Higher investments in agriculture with an overall goal of ensuring food security and reducing dependency on food aid or imports.

Appendix

Table 1: Summary: 2014-2015 Republic of South Sudan National Budget (South Sudanese Pounds)

Sector/ Spending Agency	% Total Government Planned Expenditure (TGPE)
Security	**36.6**
Transfers and Other	20.9
Rule of Law	14.3
Public Administration	8.1
Education	**5.6**
Health	**3.5**
Natural Resources & Rural Dev.	3.2
Economic Functions	2.9
Accountability	2.4
Infrastructure	**1.7**
Social and Humanitarian Affairs	0.9
Total Government Projected	10,842,316,325

Expenditure

Source: Full RSS budget: **www.grss-mof.org.** Percentages calculated by the author.

Table 2: South Sudan Health Sector Development Plan 2011-2015: Indicative Budget

COST SUMMARY SDG million	2011	2012	2013	2014	2015	Total
Operating Cost	455	579	670	791	990	3,484
Health System Strengthening	54	67	80	89	102	392
Capital Cost	119	342	342	225	207	1,236
Gross Cost	629	988	1,092	1,105	1,298	5,112
Cost per capita in US dollars	$26	$40	$43	$42	$48	
SOURCES OF FINANCE SDG million						
GOSS: 2011	216					216
DP health commitments	346	197				543
Financing Gap	66	791	1,092	1,105	1,298	4,353
Total sources required	629	988	1,092	1,105	1,298	5,112

Source: 2011-2015 South Sudan Health Sector Development Plan.

About Sudd Institute

The Sudd Institute is an independent research organization that conducts and facilitates policy relevant research and training to inform public policy and practice, to create opportunities for discussion and debate, and to improve analytical capacity in South Sudan. The Sudd Institute's intention is to significantly improve the quality, impact, and accountability of local, national, and international policy- and decision-making in South Sudan in order to promote a more peaceful, just and prosperous society.

About the Author

Juliana Bol has worked in the health sector in South Sudan for the past 5 years. She is currently pursuing a Doctorate in Public Health, International Health (DrPH) at Johns Hopkins University.

[i] Abuja+12: Shaping the Future of Health in Africa. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2524_Abuja_report_en.pdf

[ii] WHO The Abuja Declaration: Ten Years On: http://www.who.int/healthsystems/publications/Abuja10.pdf

[iv] 2010 South Sudan Health and Household Survey (SHHS).
[v] 2014-15 Republic of South Sudan Budget. Historial-outruns-and-budgets-SS-05-14-v11-2014. www.grss-mof.org
[vi] Achieving the health-related MDGs. It takes a workforce!: http://www.who.int/hrh/workforce_mdgs/en/
[vii] Key Indicators for South Sudan, National Bureau of Statistics (available online)