FORWARD-LOOKING ANALYSIS OF FUNDING AND STRUCTURAL OPTIONS FOR THE HEALTH SECTOR GOING FORWARD, AND HOW THEY COULD BE OPERATIONALISED

For: Delegation of the European Union to South Sudan, and the Ministry of Health – Government of the Republic of South Sudan
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FINAL REPORT ANNEX C: Implications of the South Sudan conflict for the health sector

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Overview

This note (chapter) focuses on assessing the implications of the ongoing conflict in South Sudan for the health sector as of mid-2017 and looking ahead. Specifically, the following are considered:

- The background to and dynamics of the current conflict (Section 1);
- How the conflict has impacted on the health sector (Section 2);
- Different scenarios as to how the conflict might play out in future, and the implications of these trajectories for the health sector (Section 3);
- Ways to maximize the role and contribution of the health sector in South Sudan in times of conflict (Section 4); and
- Key elements of a recommended approach for MoH and partners going forward (Section 5).

1. Background to and dynamics of the current conflict

SUMMARY

- Post-independence South Sudan is suffering from conflict underpinned by violent competition for political power and access to resources at national and local level, fueled by multiple grievances which are both long-term as well as those generated more recently in the course of the recent conflict which broke out in late 2013. A peace agreement signed in 2015 has not halted the fighting, with the conflict spreading to parts of the country previously largely peaceful, such as Greater Equatoria and Western Bahr El Ghazal.
- The health sector has been badly hit by the conflict, in multiple ways. As well as suffering direct destruction of health facilities and frequent looting of assets and supplies (perpetrated by armed actors on both sides of the conflict), many health staff have been displaced together with the communities they serve. Health workers and patients have been killed in attacks on facilities as well as humanitarian convoys.
- The economic crisis accompanying the conflict has drastically reduced the already minimal value of government investment in the sector and the value of health workers' salaries - $12 a month for 67% of health workers - means continued full-time employment is simply not a viable option.
- Against this backdrop a number of actors have kept up efforts to maintain delivery of essential health services to communities across the country, including faith-based providers and NGOs, with support from the international community.
- There are a number of scenarios for the conflict going forward: efforts towards a sustainable and inclusive peace deal may gradually bear fruit; the conflict could stagnate; or it could take a turn for the worse. Actors in the health sector need to plan all three of these scenarios, building understanding between the Ministry of Health and international donors on the different trajectories and their implications. The different scenarios will necessarily impact the extent of the donors' ability to support the sector and the way in which they are able to do so. But nevertheless some key principles cut across the scenarios in terms of the types of approaches which are needed: building capacity and resilience in the sector, shifting resources to the lower levels, basic service delivery adapted to the local context empowering communities, inclusivity and targeting of vulnerable populations, and better coordination based on transparency and mutual accountability.

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such as South Sudan, it is essential to fully understand the historical, political, social and economic context and to use this understanding to support an iterative process of strategy and planning. [1]

South Sudan has been afflicted by conflict for an extended period, with a long-running civil war against what is now the Sudan (from 1955 to 1972, and 1983 to 2005) followed by an internal conflict just two years after South Sudan's independence, which was granted in July 2011. This internal conflict broke out in Juba December 2013 following divisions between the senior leadership of the SPLM, and has gone through a number of phases, with a widespread and devastating impact on the country. Many of the underlying conflict drivers, including weak governance systems dominated by elites and by particular ethnic groups, and highly unequal development efforts and distribution of resources, are the same in respect of the recent conflict as they were when the south was fighting against the north prior to independence.

Initially, the conflict was largely confined to Greater Upper Nile and was between two main factions, the government and allied militias on the one hand, and the SPLM-In Opposition (IO) under former Vice President Riek Machar and aligned militias on the other. The signing of a peace agreement in August 2015 (the Agreement on the Resolution of the Conflict in South Sudan, or ARCSS) was followed by some reduction in the level of conflict across parts of the country (including parts of Greater Upper Nile). However, with the underlying causes of conflict not addressed by the peace agreement, key communities considering their interests to have been sidelined, and increasing attacks on civilians, various new rebel factions have emerged. Conflict has spilled over into many parts of the country previously unaffected, such as Western Bahr-el-Ghazal, Western and Central Equatoria. Government forces remain in control of towns (but with towns such as Yei and Wau having experienced a major exodus of the population), while opposition activities have focused on roads and have their strongholds in more rural areas.

As of mid-2017, the ARCSS remains unimplemented and there is limited – and some would say no appetite - for a political solution either on the side of the Transitional Government of National Unity (TGNU) as established under the peace agreement or that of the various opposition forces, which are fragmented. Various efforts towards peace, reconciliation and dialogue are being made but experience suggests that sustainable peace is going to be a long-term endeavour. *Different scenarios for the conflict moving forward – as well as their implications for the health sector – are considered below (Section 3).*

[1] "Strategizing in distressed contexts"/ WHO Handbook on Strategizing National Health in the Twenty-first Century (Chapter 13) – Enrico Pavignani and Sandro Colombo

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2. Impact and implications of the conflict for the health sector

The evolving conflict has impacted on health service delivery in multiple ways:

- A key impact has been the mass displacement of civilians. By April 2017, 1.74m people had been made refugees, with Uganda seeing a continuous stream of refugees since mid-2016 and 1.88m Internally Displaces Persons (IDPs), both living with host communities and in UN-managed Protection of Civilians (PoC) camps.[2] This displacement has created a burden on services in areas where displaced persons have taken refuge (urban areas, PoC camps), while leaving many small towns and more rural areas empty. A large number of people have become refugees in neighbouring countries especially Uganda. [3]
- Together with the displacement of civilians has come the displacement of health workers who equally have fled from violent conflict. Combined with the economic crisis (see below), this has left many health facilities without essential staff.
- The conflict has taken a direct toll on health facilities, struggling in many parts of the country to cope with increasing violent attacks against civilians.[4] There have been multiple incidents of the deliberate destruction of health clinics and looting of equipment and drugs by armed actors on both sides of the conflict, as well as commandeering of health facilities for military purposes. Health workers and patients have died as a result of attacks on facilities across various locations in the country as well as a result of attacks on humanitarian convoys. [5]
- The proliferation of armed factions has meant a blurring of previous conflict lines and the emergence of new ones making access a great deal more challenging. The pattern by which most urban areas are government-held and increasingly surrounding rural areas are held by or under attack from opposition groups means that movement out of the towns is increasingly dangerous. In the case of attacks on humanitarian convoys, it has been difficult to tell in many cases who these are being perpetrated by.
- Widespread food insecurity and lack of access to basic services continue to have major consequences for the health status and outcomes of citizens. As well as increasing malnutrition and hunger, there have been increased epidemics of diseases such as cholera and malaria. Various factors have historically served to limit the spread of HIV/AIDS in South Sudan, but there is clearly a risk that the recent conflict and associated mass population movements will undermine this and also cause increases in other communicable diseases, as well as causing

[2] OCHA (2017)
[3] According to UNHCR data (August 2017) the figure has reached one million, of whom 85% are women and children (http://www.unhcr.org/uk/news/stories/2017/8/59915f604/south-sudanese-refugees-uganda-exceed-1-million.html)
[4] ICRC, August 2017 (https://www.icrc.org/en/document/south-sudan-number-hungry-displaced-staggering-levels-icrc-president-says-during-visit)
[5] https://www.hrw.org/news/2017/05/24/hospitals-health-workers-under-attack

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setbacks in progress in tackling the disease burden and mortality levels (for example threatening the previous trend towards decreasing child mortality). Added to this is the immense level of psychological trauma which the war has inflicted, the impact of which will likely be evident for decades.

- Areas which have historically been underserved in health care terms, such as Greater Upper Nile, have been at the heart of the conflict which broke out in 2013 as well as being greatly affected by localized intercommunal conflict prior to the national level conflict.[6] Insecurity on the ground was compounded by an extended period (almost a year, from June 2016) during which health services in former Upper Nile and Jonglei States were not funded. The conflict has hence served to exacerbate pre-existing inequalities in access to health services, including by reinforcing the urban-rural divide.
- The conflict has inevitably placed a strain on relationships between government and donors, with increased reluctance on the part of the international community to work closely with the government until there is evidence that an inclusive peace agreement is being implemented, and that International Humanitarian Law is being adhered to. Donors have continued to fund the sector with an emphasis on working through and directly funding NGOs (due also to concerns about the high fiduciary risk associated with any funding for government). The donor approach, reinforced by the conflict, continues to be a cause of much frustration for the Ministry of Health.

The economic dimension

The economic crisis which has accompanied the conflict has also had a major impact on the health sector. The more than halving of the world oil price in 2014 had a major effect on South Sudan's economy, with government dependent on oil for well over 90% of its income. This was compounded by fields going off stream as a result of conflict, by borrowing, extensive resort to monetary financing (direct 'printing money' and otherwise), and by the government's choice to prioritise spending of the resources on the security sector. All of these reduced the effective value of the SSP: having been launched at Independence in 2011 at 3.1 SSP: 1 USD, the SSP has recently traded as low as 200 SSP: 1 USD. Price inflation has also been extremely rapid, though not quite fulfilling the technical definition of hyperinflation.

The rapid fall of the effective value of the currency and its income has had a dramatic effect on the value of funds that GRSS can budget for the health sector, which fell to as low as the equivalent of $8m p.a. at the time the FY2016-17 budget was passed, and to the reliability with which budget can

[6] Data from the recent EU-funded South Sudan Health Mapping exercise shows that there are approximately 5 facilities per 10,000 of the population in Western Equatoria and Western Bahr El Ghazal compared with an average of around 2 or less for the rest of the country (See: https://www.southsudanhealth.info/)

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be executed – with several months' gap in releases from MoFEP in early 2017.The volatility of the currency has also created practical challenges for both GRSS and partners, in getting value for money: for example, a casualty of currency volatility has been some of the progress made 2013-15 on harmonisation of health worker remuneration.

A hugely constrained health sector budget has taken a major toll on the ability of government health facilities to maintain basic operations, for example through the lack of funds for fuel to run generators, and also on the willingness of staff to remain at post when their salaries have plummeted in value and are frequently unpaid. At the same time senior government officials have continued to have access to a generous budget for overseas healthcare for themselves and their families. Badly needed drug supplies have become subject to delays as a result of increased wrangling over taxation and exemption.

Multiple operational challenges have been experienced as a result of the combined effect of the conflict and economic crisis, and have included reporting and monitoring suffering from breakdowns in the mobile phone network, and difficulties in transferring funds (for example to pay staff salaries) and in obtaining cash outside of the big cities.

The combined impact of the conflict and the worsening economic situation has created both a weakening security environment and increasing levels of criminality. There are increasing demands in some parts of government for the security apparatus of the state to have oversight of and in some cases be actively involved in the processes of social and humanitarian sectors. This has created challenges in terms of equity, and of Do No Harm.

Impact of political decisions on the health sector

Both at the national and subnational level, decision-making related to the political dynamics of the conflict has had an impact on the health sector. At the national level this has played out in various leadership changes, while at the subnational level successive redivisions of the local governance structure since December 2015 have had major implications for the sector. While in theory prioritising inclusivity in distribution of resources through bringing services "closer to the people" and this enhancing accountability, the move from 10 to 28, then 32 States [7], and from 79 Counties to over 250 Counties, has in practice due to the economic crisis dissipated already thinly spread local government infrastructure and human resource capacity.

For health services, this has entailed a rushed and inevitably disruptive redistribution of established and scarce skilled human and infrastructure resources from the former SMoHs and CHDs to a much

[7] The overall total is now considered to officially be 33 states, if the disputed territory of Abyei is included as a state.

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wider range of locations. A threefold increase in county level institutions has left some counties unable, in human and/or infrastructure capacity terms, to discharge their responsibilities. There are examples of health infrastructure being taken over to become local government offices, and of vehicles and other assets being similarly appropriated.

Despite these challenges the health sector has been able to make some of the adaptations necessary to address the new administrative structure. Health financing flows have been restructured accordingly and a number of functions which were previously at county level have been "rolled up" to the state level (give the challenge of 250 plus counties), leading to a potentially helpful consolidation.

The new structure has, however, created some tensions between states. In many instances, the new "breakaway" states are not faring as well as the "parent" state. This is for a range of reasons including a lack of access to finance in some instances (e.g. some instances of funds not being passed on by the "parent" state which continued to receive funds on behalf of the new one), grievances about perceived inequities in financial allocations and logistics, as well as a lack of interest in the taking on new service delivery responsibilities in some cases. In various instances, these grievances relating to inequitable resource allocation have exacerbated other existing intercommunal tensions leading to heightened localized conflict.

In an attempt to bypass some of these issues, MoH is seeking to "depoliticise" health sector funding by arranging direct transfers to health facilities. A pragmatic approach to clustering health allocations to geographical clusters which seem to work (such as the "lots" under the HPF and the former USAID "hubs") has been accepted by MoH.

Another development accompanying the creation of new states and counties which has impacted on the health sector has been the gradual "indigenisation" of the public service at the local level. While apparently not a nationally endorsed policy, many counties have apparently implemented a policy of only employing public servants who are members of the ethnic group/s indigenous to the area. Historically, many health workers have emanated from the Equatorias (and also Western Bahr El Ghazal), which have had better access to education and more infrastructure in terms of training facilities. Both South Sudanese from different ethnic groups to that of the host community, as well as foreign nationals (e.g. health workers from neighbouring countries) have been made unwelcome in some areas of the country and in some instances, they have been the victims of violent attacks.

While exact data on the impact of this "indigenisation" policy is not available, anecdotal evidence suggests that as a result, a number of localities are employing less qualified staff and/ or suffering a shortage of the necessary skilled workers, including health workers. There is a potential opportunity area here in terms of training locally recruited staff in the long run, enhancing the sustainability of

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capacity development efforts. However, a shortage of government resources and disruption of training programmes in the short-term means that this is not a viable approach in the short-term and that its implementation is likely to be disruptive and damaging.

3. Looking ahead: scenarios

3.1. How the conflict might develop

It is reasonable to take conflict as a given in short and medium term planning for the health sector in South Sudan. However, there are a number of different scenarios as to how the national level conflict will play out, and also how this will in turn impact on the subnational level. The conflict has already evolved significantly even within the four weeks of the inception period. To inform the development of options for the health sector going forward, three different scenarios are outlined in *Annex One.*

The three scenarios are based on (1) positive steps towards peace being achieved at the national level, accompanied by gradual resolution of local level conflict, and a degree of gradual economic recovery; (2) a situation where the conflict is stagnant and entrenched, with an ongoing economic crisis, but does not deteriorate significantly; and (3) a scenario in which there is significant further deterioration, with an increasing portion of the country affected, and further economic decline.

In each of the three scenarios, the likely impact on and implications for the health sector are spelt out, considering a number of variables. These include:

- Key changes which might affect needs in the sector (such as population movement)
- The likely government budget for health given the state of the economy
- The position which donors may likely assume towards health sector engagement
- How other related government actions might impact on the health sector (such as changes in local government structures and employment policies).

It would seem important that MoH and partners consider the implications of all three scenarios, and have a plan ready which can adapt to both a possible improvement in the security, political and economic situation, as well as a potential further deterioration. Indeed, it is quite possible that South Sudan will move in-an-out of the three scenarios over time, rather than being on a steady trajectory in one direction or the other.

In order to assist with this form of planning, it is useful to identify, both the type of responses which can be put in place in each scenario, and also some the types of actions which can be helpful across all of the scenarios. The table in Annex One seeks to start to pull out both of these (columns two and three). **Section 4** which follows discusses some of the ways in which health sector strategy,

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planning and delivery can be made as conflict sensitive as possible – responding appropriately to changing patterns of conflict, and striving to make the maximum possible impact in terms of mitigating the impact of conflict and also contributing to conflict reduction.

3.2. Scenarios in terms of local government

As noted in Section 2, the creation of new states by presidential decree (first 28, then 32, or 33 if Abyei is included) has met with a varied response. Some communities are welcoming the potential for local government to be closer to the people. However the way in which new states have been configured, as well as the impact on previous states, is contested in a number of areas of the country (for example, by the Shilluk/Chollo community in former Upper Nile State; issues in former Unity State).

It is politically unlikely that there will be a return to the former 10 states. The current 32/33 states configuration is not dissimilar to the demand for 21 states which previously formed part of the rebel SPLM-IO agenda. The need for a smaller and more standardised unit of local governance at the state level with more equitable distribution of the population and resources has a fairly high level of agreement in principle. However, the configuration of states is not wholly accepted and remains contested. It is therefore likely that in due course, some concessions will need to be made by the government to address the grievances of those communities who are unhappy (potentially as part of a renegotiation of the 2015 peace agreement, even though the government is presently indicating it is not willing to reconsider the agreement). The government is also coming under pressure to create additional states although there is resistance to this on both political and economic grounds.

It therefore seems to make sense in the context of health service delivery to assume a continuation of the configuration of somewhere in the region of 32 states, and to work towards a model of state, country, payam and boma functions and responsibilities in health sector which can map onto whatever the eventual "political settlement" might look like in terms of local government structures. In practice, the payam level is an important one given that there is roughly one PHCC per payam. The Boma Health Initiative (BHI) is likely to develop in a way which gives important responsibilities to the payam/PHCC level (*see chapter XX/ cross-reference to BHI section*).

More work on the division of responsibilities in the health sector to the various levels (federal/ national, state, county, payam and boma) is needed in the light of these political changes, ensuring that financial transfers are structured so as to enable these responsibilities to be fulfilled, and also that there is a strong model of coordination, oversight and accountability. Within this, careful attention needs to be given to the question of how the central (likely federal) MoH is able to effect change at the local level which is designed to be the key focus of future service delivery efforts, for

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example through the BHI. This may include but should not be limited to the option of direct financial transfers to the local level (e.g PHCCs).

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4. The role of health service provision in conflict

Conflict sensitivity

The health sector plays a critical role in conflict situations as well as in the context of a transition to peace. There are a number of ways in which the delivery of health care can potentially exacerbate conflict, and thereby "do harm" to the populations it intends to serve. At the same time, actions to mitigate these risks can help to "do no harm", preventing a worsening of conflict on the one hand, and also helping to mitigate the impact of conflict and in the best case, actively contribute to conflict reduction. Some examples are provided in Table One.

Responses to date: has health care delivery been conflict sensitive?

The different pressures described in Section 2 have combined to make the delivery of basic healthcare services highly challenging. Nonetheless, a degree of continuity in terms of the delivery of a basic package of services has been largely maintained across most of the country, through a combination of government and NGO supported facilities (including faith-based organisations). The multi-donor "Health Pooled Fund" (HPF) has covered eight of the former ten states, with two states (former Jonglei and Upper Nile) covered by the World Bank Funded Rapid Results Health Project (RRHP) implemented by IMA.

Evidence suggests that NGO providers under the HPF have not only enabled service continuity in a way which has been largely conflict sensitive in terms of "do no harm", but have also been able in some cases to extend services to displaced populations in their new locations through mobile health facilities, particularly supporting the provision of emergency services targeting vulnerable populations such as women and children, hence operating at the "mitigation" level.[8] Where possible, additional HPF funds have been allocated to complement emergency efforts by humanitarian actors.

Over and above this, there is important evidence that government service delivery has in its own way sought to be conflict sensitive, at the level of MoH. Specifically, it is reported that for a significant period of time, efforts were made by MoH to ensure continued service delivery in opposition areas, by seeking to make sure that funds to pay the salaries of health workers in opposition-held areas (who were still viewed as ministry staff) were able to be transported "across the line", as well as supplies such as pharmaceuticals. Where obstacles were met, for example in obtaining the relevant permissions, senior MoH personnel were involved in lobbying for access with the responsible authorities at a high level, with the minister also chairing an internal cross-government committee designed to help sustain basic services across the country. As well as

[8] Annual Review of the Health Pooled Fund (DFID, December 2016)

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seeking to sustain essential services in opposition areas, MoH has also previously expressed interest in finding ways to serve populations in the various Protection of Civilians (PoC) sites, although this did not come to bear and this has been covered by international as well as national NGOs. It is worth noting that there was a greater degree of success in this respect than in the education sector.

However, anecdotal evidence suggests that this informal policy of sustaining services in opposition areas is not being implemented as consistently as during earlier stages of the conflict. This could be for a variety of reasons. Attitudes have hardened as the conflict has continued and mutated, meaning that more restrictions are imposed by the authorities and there is more involvement of security agencies. Government policies outlined in section 2 relating to local government restructuring and "indigenisation", while not emanating from MoH, have also in some instances had a negative impact on the health sector in conflict sensitivity terms.

There are also some ways in which donor service delivery models have not been adequately conflict-sensitive. For example, the way in which the country has previously been apportioned to different donors and delivery approaches (through a "zoning" approach), which still continues to the extent that Greater Upper Nile (former Upper Nile, Unity and Jonglei States) is covered by the RRHP, has entrenched inequalities in service delivery between some of the main ethnic "blocks" of the country. The continuing policy under the HPF of allocating "lots" to different Implementing Partners (IPs) equally risks reinforcing social inequity as well as ethnic tensions if not carefully managed to ensure that inequitable access is addressed and that intercommunal grievances and tensions are not exacerbated. The treatment of PoC sites as for humanitarian provision only also reinforces social divides and fuels tensions.

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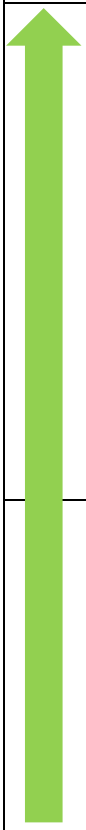
Table One: *How can the health sector respond to conflict?*

	Level	**Dimension of conflict sensitivity**	**Examples**
	Conflict reducing	Proactive contribution of healthcare interventions to conflict reduction	• Promoting diversity and equity within health sector cadres and delivery at all levels • Tailoring local service delivery responses to meet local needs, especially in challenging areas. • (Re)building community resilience • Linking health and education services to enhance accessibility • Creation of local level community networks and structures, with active empowerment of women as key actors, which can then also contribute to peacebuilding and reconciliation.
	Mitigation	Mitigation of conflict impacts through healthcare interventions	• Proactive targeting of conflict-affected areas • Efforts to maintain continuity of service delivery (including payment of health workers) to populations living in opposition-held areas • Adaptive/ flexible models of service delivery • Support to priority/ vulnerable population groups (e.g. IDPs, women) • Priority support for conflict-related needs (SGBV, trauma etc) • Lending support to emergency and humanitarian interventions
	"Do No Harm"	Avoiding healthcare interventions causing harm or exacerbating conflict	• Approach based on equitable access • Allowing HWs to relocate when they feel endangered
	Harmful	Health service delivery exacerbates conflict (directly or indirectly)	• Working only in areas controlled by one side in the conflict • Alienation of communities (e.g. through destruction of facilities, discriminatory policies, perceived or actual inequities in resource allocation) heightens conflict risk

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Looking ahead: the health sector can both mitigate and reduce conflict

There is scope for the health sector in South Sudan to play an enhanced role, not only ensuring that service provision "does no harm", but also supporting the mitigation of conflict impacts as well as actively contributing to processes which can help bring about sustainable, long-term peace.

With so many people on the move, it is vital that health services are able to adapt quickly and efficiently to an evolving population map and evolving distribution of those it is seeking to support: this is likely to imply a dynamic, and thus potentially formula-based and mobile, rather than static and territory- or infrastructure-based, approach to service funding and delivery. It is also vital that the package of services offered can adapt to the needs of a population on the move and/or fragilely housed. To support this kind of adaptability, managers and frontline workers like need to be trained to be able to respond flexibly and with initiative in times of crisis, with adequately devolved decision-making and access to basic resources. Different approaches and delivery models may be needed in different settings to respond to local patterns of need.

Over and above this, recent academic work has highlighted that social services in South Sudan including health and education services have a crucial role to play in sustaining the social fabric. [9] These have been shown to be "anchors" for communities in their locations, with striking increases in enrolment in the education sector during periods of conflict, and the availability of local services being an important 'pull factor' for returns. Churches and clinics have been shown to be important multi-ethnic institutions at a time when political and communal tensions are creating huge social rifts and ethnic divides.

More broadly, international experience points to the importance of health services in building resilience to shocks in times of conflict. As well as contributing to the physical and emotional resilience of communities, healthcare provision can also achieve other important impacts such as rebuilding trust and communication within and between communities damaged and divided by conflict.

Gender

Men and women have been disproportionately affected by the conflict. It is evident that across much of the country, women are bearing the brunt of the conflict in terms of finding safe locations for their families (with access to services where possible), struggling to care for and feed children, as well as direct impacts on their own health and well-being, including an alarming level of sexual and gender-based violence (SGBV) as a result of rape increasingly being used as a tool of war and to

[9] "South Sudan: wrong turn at the crossroads?" Eddie Thomas and Natalia Chan in *Humanitarian Exchange* Number 68 January 2017

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intimidate communities. Insecurity in both towns and rural areas has made access to emergency obstetric care and safe delivery extremely difficult. The provision of basic health care and essential medicines, with a strong focus on maternal and child health as well as responses to SGBV, is of prime importance to women.

The ability of both male and female health workers to perform their duties has been considerably disrupted as a result of both the conflict and the economic situation (due to displacement and also with delayed payment of salaries by government a recurring problem). It is likely that female health workers have been particularly hard hit, with a major impact on professions such as midwifery, where there was already a problem of high drop-out levels prior to the conflict which has likely been exacerbated.

The opportunity areas for the health sector to contribute towards recovery include putting in place policies which prioritise the needs of women both as beneficiaries of healthcare (with a strong priority on maternal, reproductive and child health), and also in their role as health service providers.

Other vulnerable populations

South Sudan is a rich mosaic of different communities and ways of life. Models of service delivery need to be targeted to the needs of different population groups. Pastoralist communities make up a considerable proportion of the population – particularly in Greater Upper Nile but also, as a result of internal migration and displacement – now across much of the country. Urban centres are now hosting large internally displaced populations which also need to be catered for.

5. Conclusions: a health sector in South Sudan which builds resilience

In summary, a range of policies can be put in place in the health sector which can not only try to ensure that health delivery "does no harm" but also help to mitigate the effects of the conflict and contribute towards conflict reduction and recovery. Some of the key lessons emerging include the following:

- Given the changing nature of the conflict, there needs to be constant adaptation to the context. MoH and its partners (other government agencies, international donors and the various implementing partners in the sector) need to come together on a regular basis to review changes in the context, discuss priority needs in the light of these, and adapt programming and resource allocation accordingly. This joint approach to ensuring the conflict sensitivity of health sector delivery can reap potential benefits at all levels.

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- MoH and partners can work together to frame a "conflict sensitive sectoral approach" which can guide the sector.[10] In the absence of progress in implementing an inclusive peace agreement, donors are likely to be reticent about engagement with national level government. In this scenario (both the "stagnation" and the "deterioration" variants), the main opportunity areas to make an impact are likely to be at the subnational level and specifically, at county and boma level where primary health care services are delivered. MoH and partners can put in place plans to focus strongly at this level whilst also planning for a gradual expansion of the scope and approach of sector-wide support, including a strong focus on national capacity and systems development, as peace is restored and as economic circumstances improve. This type of carefully planned engagement can avoid the necessity to withdraw sectoral support and "retreat" to a humanitarian only approach in times of conflict.
- There is scope for the international community to advocate strongly for the type of government policies which can reinforce rather than undermine conflict sensitivity, such as the continued provision of salaries and logistics to opposition areas.
- There is no one blueprint as to the type of approach which is needed. The health sector in South Sudan can learn from experience in other conflict-affected countries but cannot take a "one size fits all" approach given the vast complexity of the South Sudanese context (see section on lesson-learning from international experience). Approaches will need to be tailored to the differing local contexts, building on what has been in place historically while shifting emphasis and resources to tackle inequalities in service provision and access as well as changing patterns of need resulting from the conflict.
- Given population movement and a rapidly shifting situation at the local level, and the possibility that it could take time for peace to be reached and the country as a whole to be stabilized, models of service delivery which deliver flexibly (outreach and mobile facilities at the boma level) are likely to be most cost-effective at the current time and also for the foreseeable future. Intersectoral collaboration offers great potential, for example with the education sector (e.g. to make use of school facilities for mobile health sector delivery).
- MoH and partners need to work together to maximize access to services geographically, ensuring equitable resource allocation to the lower levels which takes account of current inequalities in access, and priority targeting of vulnerable groups (women and children, displaced & returnees). In the short-term, key priorities include finding ways to enable better access for women in times of insecurity to emergency obstetric care and safe delivery.

[10] "*Integrating conflict sensitivity into sectoral approaches*" (Chapter 4, Resource Pack on Conflict-Sensitive Approaches, FEWER, International Alert and Saferworld 2004).

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- Policies are needed which recognise the severe challenges being faced by health workers, to encourage them to stay in the country and in the sector. This includes recognizing the need for doctors to work flexibly both in government facilities and in private practice.
- Different models of partnership between MoH and service providers (NGOs, faith-based and private providers) can help to address the diversity as well as the complexity of the context. There is scope to develop these different models further, for example building on the extensive experience of faith-based providers in the South Sudan context. Lessons can be learnt in terms of approaches which have worked in South Sudan in the past and which can be built upon going forward. [11]
- There are important opportunities to focus on support to and training of HWs which builds resilience, skills and ability to adapt to and cope with the challenges they face, as well as to contributing to local level problem-solving and the building of community cohesion.
- Hospitals and health centres (together with schools) can be an important part of a strategy to build civic spaces which can help protect civilians and prevent further violence by promoting intercommunal harmony. Local ownership and community participation is key.

[11] One example is the role of the Catholic Diocese of Torit (RCDoT) in running local health services starting in the 1990s.

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ANNEX ONE: Conflict scenarios, implications for programming, and approaches which can help

SCENARIOS	**Implications for programming: *maximizing the contribution of the health sector***	**Approaches which can help across all three scenarios**
1) <u>Progress towards peace ….</u> *over the next 2-3 years* • Gradual progress towards peace agreement & a more inclusive political settlement • Stabilisation of conflict-affected areas, greater access • Donor- government relations improve • Stabilisation of the economy, increased government budget flows. **Impact on the health sector**: • The limited government budget is released: salaries paid, HWs at post, willing and able to work • Basic package of services can be delivered across the country • Gradual returns (IDPs and refugees); need to rebuild infrastructure.	• Health as a priority sector in terms of contribution to peace/peace dividends • Focus on service delivery to war-affected areas, restoring services • Focus on enabling IDP & refugee returns • Starting to tackle conflict drivers through tackling inequitable service delivery & access • Flexible allocation of staff geographically to help tackle inequitable service delivery. • Greater scope for alignment with government at both national and subnational level • Scope for a greater focus on national systems strengthening and capacity development	• Updated MoH-development partner compact which sets out engagement under different scenarios and benchmarks, with agreed responses/ conditionality, transparency and mutual accountability. • Constant adaptation to the context • Models of service delivery which deliver flexibly (outreach, mobile facilities; boma level etc). • MoH and partners work together to maximize access to services geographically • Targeting of vulnerable groups: women and children, displaced & returnees etc. • Different models of partnership between MoH and NGOs/ faith-based and private providers. May need pluralistic model which reflects diversity and the

2) <u>Stagnating conflict</u>
 	
• Ongoing fighting between government and rebels – shifting dynamics: ongoing displacement – some areas improve, some deteriorate
• Conflict mainly affects areas outside of the capital. Key towns remain in government control.
• Economy bad but not a major crash: salaries paid late but some ongoing payments
Impact on the health sector:
• Service delivery only possible in some areas
• Donors focused on basic / essential service delivery at
	• Need for adaptive approach:
	  o Support to conflict reduction /mitigation through health care.
	  o Ensuring health service provision does not exacerbate tensions.
	  o Flexible / responsive models e.g. building health workers' ability to be responsive to crisis and shifting patterns of need.
	• Protection of HWs and civilians
	• Responses to violence (including SGBV/CMR) + life-saving interventions	

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the local level; limited appetite for national level capacity development and support.	• Essential medicines/ supply chain high priority • Sustaining service delivery in opposition-held areas. • Some scope for subnational level support , but weakened local government requiring more direct focus on service delivery units (SDUs) and non-governmental service delivery	complexity of the context. • Intersectoral collaboration – e.g. with the education sector • Focus on HW support and training which builds resilience (adaptability, a degree of autonomy, skills to cope with change/ problem-solving) • Maximizing the contribution of health services to building community level cohesion. • Joint approach to ensuring conflict sensitivity developed by MoH and partners at all levels.
3) <u>Deterioration</u> *(ongoing/ gradual)* • More rebel factions, more conflict-affected areas (e.g. deepening conflict in the Equatorias, WBEG); potential deepening of conflict linked to rejection of new states in some areas (e.g. Shilluk/Chollo). Possible attacks on government held urban areas (as currently happens in Wau, could spread e.g. to Juba). • Economic slide continues; unrest over unpaid salaries • Greater fragmentation of local government and local service delivery. • Potential total loss of state legitimacy **Impact on the health sector:** • More areas affected by HW and population displacement; communities denied access to services; ongoing destruction of facilities and assets. • More rebel-held areas (mainly rural) – challenge of maintaining health services in opposition areas • Difficulty transferring funds. Salaries remain unpaid/ increasing arrears. • Continued policy of "indigenization" means health workers in some areas are less or unqualified/ increasingly inequitable allocation of more qualified HWs. Limited opportunities for training to address the needs.	• Likely donor shift towards humanitarian/ emergency programming through NGOs. *Need to define what basis donors can engage with government in this scenario (e.g. around the maintenance of emergency services, access; systems to support alignment of efforts).* • Worst case scenario of total collapse including loss of most HWs – *how to plan for this.* • Expansion of PoCs – *can/ should MoH play a role in priority service delivery in PoCs?* • Some of the areas which are potentially heading towards being highly conflict-affected are those which have previously had better access to basic services (e.g. Equatorias). Related need to protect health personnel and infrastructure wherever possible (e.g through more work with armed groups on both sides on IHL responsibilities). • High level of need for emergency services, trauma response, sexual violence support services. • Advocacy efforts by MoH and development partners in support of nationwide service delivery including in opposition-held areas.	

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