



CRITICAL DIAGNOSIS:
**The Case for Placing South Sudan's Healthcare System
at the Heart of the Humanitarian Response**





CARE places special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty.

CARE's commitment to health care in South Sudan

CARE works closely with the South Sudan Ministry of Health (MoH) through partnerships with seven County Health Departments (CHDs) in two of the states most heavily affected by violence.

CARE's original funding from the World Bank via Interchurch Medical Association (IMA) and the Health Pooled Fund (HPF) via Crown Agents was to provide management support to CHDs. With the conflict, CARE has had to change its approach. The conflict has increased health and nutrition needs while insecurity has reduced access to adequate healthcare for patients. Unfortunately, at the same time, the conflict inhibits state and county officials from visiting facilities and supporting the healthcare administration, including the provision of salaries and medicines. This is especially difficult in remote areas or those no longer under government control. Therefore CARE and other NGOs are working more closely with each healthcare facility to assist the MoH in filling these gaps. CARE is currently working with health facilities in seven counties in two states in South Sudan: Mayom, Abienmon, Rubkhona, Guit, Pariang (Unity), and Twic East and Uror (Jonglei).



ACRONYMS

ANC	Antenatal Care	IPC	Integrated Food Security Phase Classification
ARI	Acute Respiratory Infection	MCHW	Maternal Child Health Worker
ART	Antiretroviral Therapy	MoH	Ministry of Health
AWD	Acute Watery Diarrhea	MSF	Médecins Sans Frontières
CHW	Community Health Worker	OECD	Organization for Economic Co-operation and Development
CO	Clinical Officer	PHC	Primary Healthcare
DHIS	District Health Information System	PHCC	Primary Healthcare Center
DfID	Department for International Development (UK)	PHCU	Primary Healthcare Unit
DOTS	Directly Observed Treatment, Short-Course	SGBV	Sexual and Gender-based Violence
EMF	Emergency Medicines Fund	SRMH	Sexual, Reproductive and Maternal Health
EPI	Expanded Program on Immunization	SSHS	South Sudan Household Survey
GAM	Global acute malnutrition	TBA	Traditional Birth Attendant
HMIS	Health Management Information System	UNMISS	United Nations Mission in South Sudan
HPF	Health Pooled Fund	USAID	United States Agency for International Development
HSDP	Health Sector Development Plan	VHC	Village Health Committee
iCCM	Integrated Community Case Management	WASH	Water, Sanitation and Hygiene
IDP	Internally Displaced Person	WHO	World Health Organization
IMA	Interchurch Medical Association		
IP	Implementing Partner		

Executive Summary

Even before the current civil war in South Sudan, CARE estimates that almost 300 women died every day in childbirth¹. One year into this conflict, even more women are dying in child birth and as a result of the secondary consequences of the conflict that shows little sign of ending.

Agencies, including CARE, have been working hard to save thousands of lives by responding to high levels of food insecurity and malnutrition, preventing and responding to diseases such as cholera, vaccinating children and ensuring that people have clean water. However, the conflict has weakened an already challenged local health system, with infrastructure destroyed by the fighting, staff and humanitarian workers targeted or displaced, and parallel and separate delivery of basic services not making the best use of limited resources.

In this context, humanitarian response alone cannot overcome the structural issues that plague the provision of basic services in South Sudan. Despite this, CARE believes that real impact *can* be achieved by investing in health interventions in South Sudan at the local level, aligning humanitarian actors and support alongside local health workers and structures to serve the needs of the South Sudanese people.

In a context of overwhelming challenges and needs, the local health system is one of the best placed institutions to save lives now and in the future for two key reasons:

1. Evidence shows that the highest causes of death in conflict in low income countries is not direct violence but are as a result of the secondary impacts of war, such as disease, hunger, the destruction of markets and infrastructure and the massive disruption to livelihoods caused by people fleeing from the conflict.
2. In South Sudan, the local health system has a much greater level of coverage of communities compared to humanitarian health services, with approximately 1400 facilities around the country. Often, health facilities are one of the only permanent concrete structures in communities and health workers are uniquely visible and engaged. Strengthening the local health care system will also serve to speed up the responsiveness of the overall system, often slowed down by bottlenecks at the national level.

Research for this paper focused on the three conflicted-affected states (Jonglei, Unity and Upper Nile) where CARE works and finds that some of the structural issues could be addressed at national level. It details the major health concerns in South Sudan prior, and subsequent to the ongoing crisis and argues that the health care system is unable to cope with the current and potentially increasing levels of humanitarian need.

In this challenging context CARE believes there are four actions that donors, humanitarian actors and the authorities can take to immediately strengthen the local health system, saving lives now and into the future.

1. **Enhance the Decision Making power of Local Health Care Providers.** Tailor decision making to enable the health system to appropriately respond to the unique situation of each location. For instance allowing local health administrators to use traditional birth attendants more frequently instead of midwives, ensuring local health workers can inform drug procurement so that they get specific drugs they need, and improving information sharing between local health workers and within the hierarchy of the health service.
2. **Integrate Nutritional Programming within the Local Health System.** Despite MoH policy, nutrition and supplemental feeding is not currently part of the basic package of primary health care supported by donors. However, given the strong links between ill-health and hunger, integrated services would boost both nutrition and health outcomes in South Sudan by incentivizing people to attend clinics, and avoiding the situation where families are forced to choose between medicine or food if they cannot physically get to both service facilities. The current blockages to integration should be addressed. These include nutrition focused actors working in parallel to health ones, supplies not being made available to health providers, and the need for a small amount of additional training for some staff.

- 3. Enhance Community Outreach.** Both humanitarian actors and local health providers should increase their outreach programmes to help identify and treat health problems more effectively and help to build the relationships with communities that will encourage them to attend health facilities more regularly. Outreach services can also improve women’s access to healthcare, overcoming problems of distance, time, resources and sensitivity. Donors should prioritise multi-sectoral outreach approaches such as the integrated Community Case Management (iCCM) approach. This should be integrated with greater support for nutrition, Sexual, Reproductive and Maternal Health (SRMH), and Sexual and Gender Based Violence (SGBV) services and referral mechanisms, as well as the full implementation of the Call to Action commitments to combat violence against women and girls in emergencies.

- 4. Create Mechanisms for Greater Community Involvement in the Healthcare System.** Strengthening the participation of community members, civil society and local authorities in health can improve community health outcomes, particularly by mobilizing support for health goals and holding providers to account on quality and effectiveness. CARE believes that Village Health Committees must be strengthened, even in emergency contexts. Tools such as the community scorecard approach can facilitate greater community engagement and ensure that the needs of communities are better understood and attended.

Ultimately, as long as the conflict remains unresolved, people will suffer and die from preventable diseases, complications arising from malnutrition and hunger, and from widespread sexual and gender based violence. However, in this context, strengthening localized healthcare can assist in saving lives and be complementary to the short term emergency response as well as helping to build longer term resilience.

It is with this understanding in mind that CARE believes that for now and the future, the greatest impact can be achieved by focussing health interventions in South Sudan at the local level, bringing together the efforts of humanitarian actors and local health workers to best serve the needs of the South Sudanese people at this critical time.



The Setting for Healthcare in South Sudan

INDICATORS

The health system in South Sudan is one of the world's most under-developed. Primary healthcare coverage is low and mortality rates high. The primary causes of morbidity and mortality are diarrheal diseases, acute respiratory tract infections (ARI), malnutrition and malaria. Malaria alone accounts for 25 percent of all deaths² and 20 to 40 percent of all patient visits³. Compounding and contributing to the high rates of disease prior to the conflict are the realities that only 70 percent of the population had access to clean water, only 13 percent had access to sanitation facilities⁴ and only 32 percent of children under one were fully immunized⁵. Knowledge about and access to nutritious food was also limited. Micronutrient deficiencies are common, as is hunger. In 2013, there were approximately 4.3 million food insecure individuals⁶, with an average of 10 percent of the population severely food insecure in the three years prior to the crisis⁷. Further, only 20 percent of children 0-11 months were estimated to be adequately fed⁸.

Lack of access to and provision of sexual, reproductive and maternal health (SRMH) services is also a factor in high rates of morbidity and mortality. In South Sudan one in seven mothers dies from pregnancy and birth-related complications⁹. Utilization of antenatal care (ANC) is only 4.8 percent and 80 percent of women give birth at home¹⁰, often only visiting a facility if they are able to get to one if and when complications arise.

INDICATOR	ESTIMATED RATES
Able to access healthcare within 5 km	40% ¹¹
Maternal mortality	1,989 per 100,000 live births ¹²
Infant mortality	75 per 1000 live births ¹³
Under 5 childhood mortality	121 per 1000 live births ¹⁴
Deliveries at home	80% ¹⁵
Percentage of children who are underweight, stunted and wasted ¹⁶	28% ¹⁷
Severely undernourished (children under 5)	122 per 1000 ¹⁸

COVERAGE

There is a lack of public confidence in and access to health facilities,¹⁹. Approximately 1400 Primary Health Care Units (PHCUs) and Primary Health Care Centers (PHCCs)²⁰ provide the majority of healthcare in South Sudan at a ratio of over 7000 people per facility²¹. While they can treat the majority of illnesses that cause mortality and morbidity, they are often unable to respond to health issues requiring more complicated procedures and must refer these to hospitals. Unfortunately, in 2012 it was estimated that there were only 37 hospitals across the country some of which have been made non-functional due to the conflict. Others remain difficult to reach, particularly during the five to six months when seasonal rains cut off vehicle access to roads.

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FUNDING

The healthcare system has long been highly reliant on external funding. Eighty percent of healthcare services are provided by NGOs²² and four-fifths of South Sudan's 2012 healthcare budget was from external funds²³. The government's 2014/2015 fiscal year draft budget calls for \$75.9 million for health. This includes approximately \$23 million for the 37 tertiary and secondary health facilities in South Sudan. Of that figure, about one-third is for only 3 hospitals²⁴. Comparatively, the approximately 1400 PHCCs and PHCUs staffing the vast majority of health administrators, providers and patients are intended to receive only 24.4 percent of total planned expenditure, excluding donor funding. These figures do not account for absence of budget outturn for community and public health from July through December 2013.

'THREE-SPHERE'²⁵ HEALTH FUNDING SYSTEM

To ensure that healthcare coverage is comprehensive and effectively coordinated, from 2011 the Ministry of Health (MoH) worked with donors to allocate assistance for PHC on a state-specific basis. The DfID-led Health Pooled Fund (HPF) supports six states with USAID and the World Bank each supporting two. Each maintains its own relationship with the MoH and has contracted fund managers for sectors of responsibility. Fund managers further contract implementing partners (IPs) on a county-wide basis. While there are differences in how fund managers and IPs support facilities, common challenges across the system include the payment of salaries in opposition-controlled areas, timely provision of medicine and staffing payments.

Although the conflict has compounded its challenges, since its start, the 'three-sphere' system faced obstacles.



Independence came with an escalation in humanitarian need due to inter-tribal violence, border skirmishes, and an influx of returnees from Sudan. In January 2012, six months after South Sudan's independence, South Sudan halted oil production, a vital revenue source. This took place concurrent with the phase-out of the previous international funding mechanisms and the initiation of the 'three-sphere' system. While the 'three-sphere' system was intended to place greater management of healthcare under the authority of the national MoH, plans were stalled by the lack of the government capacity to meet contractual obligations. Some shortfalls were filled by fund managers and NGOs who redirected grants to pay staff and defer transfer of others to government payrolls. With regard to drugs, USAID, DfID and Norway created the \$48 million Emergency Medicines Fund (EMF) to bridge funding deficits. The EMF will end in September 2015 and the MoH is currently developing its pharmaceutical procurement plan.

Sectors of Operations for South Sudan Health Donors, the 'Three-Sphere' System

DONOR	STATES	IP RESPONSIBILITIES
Health Pooled Fund (UK, Canada, Australia, Sweden and the European Union)	Unity, Lakes, Warrap, Eastern Equatoria, Western Bahr el Ghazal and Northern Bar el Ghazal	<ul style="list-style-type: none"> • Salary payments at PHCC & PHCU level • Weekly reporting • Capacity building of CHD staff²⁶ • Site rehabilitation and furnishing
World Bank	Jonglei, Upper Nile	<ul style="list-style-type: none"> • Provision of BPHS through salary and incentive support • Weekly reporting • Capacity building of CHD staff
USAID	Central Equatoria, Western Equatoria	<ul style="list-style-type: none"> • Healthcare System Strengthening • Integrated Service Delivery Project

Health Under Fire

South Sudanese, like most people in the midst of conflict, face increased disease burden. The conflict has:

- Intensified the rate of already prevalent diseases, including malaria, ARI, and diarrhea.
- Caused a resurgence of previously dormant diseases such as visceral leishmaniasis (kala azar).
- Further precipitated outbreaks of measles and cholera.

In addition to these factors, treatment models dependent on uninterrupted delivery of care (including ART for HIV/AIDS, DOTS treatment of tuberculosis) are at risk of disruption. At the same time, unmet psychosocial and mental health needs and declining access to primary healthcare and SRMH services have greatly exacerbated health risks. In this environment, the elevated levels of food insecurity and malnutrition consequent of conflict will likely have even more severe consequences as they weaken immune systems, inducing and aggravating illness while constituting a medical emergency in itself. The health care system in the three conflict-affected states, fragile before the conflict, is even now less able to cope with increased need.

INCREASED RISKS FOR IDPS

IDPs travel without adequate shelter, food or water over long distances and settle in environments to which they are unaccustomed. They have greater exposure to insects that produce disease, including the mosquitoes and sand flies that cause malaria and kala azar respectively. They are often likely exposed to sexual and gender-based violence (SGBV), have heightened levels of stress and have limited access to safe water and sanitation facilities. Further, they have likely suffered a loss of assets including personal items, looting of their food sources including cows as well as loss of community infrastructure including boreholes.

INCREASED RISKS FOR WOMEN

Just as women's already high SRMH risks have increased with the crisis, the functionality of some clinics has been reduced and insecurity and displacement have made many facilities less safely accessible. According to respondents, SRMH visits have declined in some locations in South Sudan because medicine and incentives normally provided to patients have run out. SGBV has also been a persistent feature of conflict in South Sudan. In some areas, ongoing violence, insecure living environments and concentration of armed men have increased risks of forced sex while

the loss of income-generating opportunities and assets amidst increasing food insecurity has contributed to incidents of sexual exploitation and early marriage²⁷.

Sexual violence can result in significant health concerns including physical and psychological trauma, sexually-transmitted diseases and unwanted pregnancies. SGBV may also threaten the psychological well-being of survivors and their families, diminish survivors' caregiving abilities and potentially reduce their capacity to engage in economic pursuits. These risk factors are compounded by the postponement of SGBV-related training and programming in some areas of the country, and more generally by the lack of women among healthcare providers, administrators and decision-makers.



The Head Chief

The head chief of one remote payam worries about the great suffering he sees ahead, particularly hunger. There are few crops, no cows and no fishing. Most of the 50,000 people in this payam eat only one meal a day. The elders tell him that they have not seen so much suffering since 1991 and that they expect worse to come. Hunger is already resulting in sickness and almost every family has a member stricken with illness.

While he hopes for peace, the chief is prepared to lead residents to Ethiopia later this year in search of food. He knows that many won't make it but in the absence of outside assistance, they are left with few options. There are also concerns that if attention to this crisis and funding doesn't increase, CARE might also leave. As it is the only organization supporting many of the seven bomas he administers, "if they left this village, they would lose all hope" he explains. The chief points to the surrounding houses, **"If you were to ask me to see malnourished children, hungry mothers without milk for their babies, I could call to all of these houses and gather them for you now."**

INCREASED ACUTE MALNUTRITION

In all areas of the country the food security situation had been improving prior to the conflict. However, in its wake many families have exhausted their livelihood mechanisms and lost access to others. This includes cows whose milk constitutes a primary staple. Insecurity has also disrupted seasonal agricultural practices, deterring some from planting or reducing the acreage under cultivation. Markets not only supply 30 percent of all household food consumption, they are a primary source of staple goods and dietary diversity²⁸. Unfortunately, in some areas staple foods have become more expensive, less plentiful and sometimes unavailable. Finally, families that remained in their villages often host IDPs, straining limited resources.

Due to these factors, people's diets are changing, leading to micronutrient deficiencies precisely when they require greater micronutrient intake to combat the increasing prevalence of disease. The results are particularly troubling for children, pregnant and lactating women and their children.²⁹ Health concerns are further exacerbated by a lack of food. Families interviewed by CARE report reduced caloric intake; some have no food whatsoever and rely on water lilies, tree leaves, seeds and sometimes unripe crops. These hardships are reflected in the most recent Integrated Food Security Phase Classification (IPC) report which found levels of global acute malnutrition (GAM) above emergency thresholds in some areas. The IPC report also estimates that through December 2014, 1.5 million individuals will be in crisis or emergency levels of food insecurity. Once the limited harvest reaped is exhausted, communities will face even greater hunger, particularly from January through March 2015 when the IPC report estimates that the number of individuals in crisis and emergency food insecurity will reach 2.5 million³⁰. The World Food Program and its partners have done incredible work to get food to as many people as possible, and have mitigated some of the most extreme food insecurity and malnutrition. However, as these actors are the first to acknowledge, food drops and distributions have limited, time-bound impacts; they cannot address malnutrition's underlying factors nor its health impacts.

LOGISTICS OF SERVICE PROVISION

The conflict has exacerbated the steep logistical challenges faced by those working in South Sudan. In some areas, service providers struggle with insecurity-related challenges on mobility. Looting has also reduced

the functionality of some facilities, depleting stocks of foods, medicines, and other goods. The vaccine cold chain has been disrupted in crisis-affected counties with partners resorting to more expensive, improvised measures to ensure immunization of children. There are also bureaucratic impediments including regulations on the movement of cash, fuel, communications equipment and even medicine. Obtaining clearance for flights and travel can also be complicated and time-consuming. Combined, these challenges result in lower quality of healthcare services and increased costs.

ATTACKS ON MEDICAL FACILITIES

The extent of the violence levied against health workers, facilities, transport and patients in South Sudan has been called "unprecedented." Approximately 127 health facilities are non-functioning due to looting, damage, destruction and the flight of staff³¹. In Jonglei and Upper Nile states alone only 55 to 58 percent of healthcare facilities remain open. Further, according to a report by Médecins Sans Frontières (MSF), at least fifty-eight people have been killed on hospital grounds³² between December 15, 2013 and June 15, 2014. If attacks are intended to deny health care to potentially hundreds of thousands of people in order to increase mortality in areas controlled by opponents, they contravene international humanitarian, human rights and customary law.

HEALTH FUNDING

Governmental budgetary outlay for health is recurrently low, and since the outbreak of violence is likely to have decreased due to budget redirections. At the same time, costs of running humanitarian operations have soared due to the loss of assets, restrictions on mobility, relocations of offices and staff, higher costs of procuring goods, greater expatriate skill requirements and escalating need. CARE estimates that the cost of managing healthcare programs has doubled or tripled in some areas. International donors have helped fill the gap. Of the \$77 million emergency plea for essential life-saving health services, 81 percent has been met³³, though this figure is lower if epidemic response is included. Unfortunately, funding for nutrition remains low, with a gap of \$71.8 million for essential emergency services³⁴. An additional concern is that, in more stable areas, deferments of development funding have occurred; just as these communities need support the most they are seeing the foundations of their stability threatened.

Investing in Local Healthcare Systems: Four Categories of Intervention

From the signing of the 2005 Comprehensive Peace Agreement, donors have worked with the government to design a health system that supports PHC, and the MoH objectives resonate strongly with needs on the ground, WHO guidelines and approaches to meeting Millennium Development Goals. This is illustrated in the Health Sector Development Plan (HSDP) 2012-2016 pledging “to increase the utilization and quality of health services, with an emphasis on maternal and child health; to scale up health promotion and disease prevention interventions, to empower communities to take charge of their health; and to strengthen institutional functioning including governance and health system effectiveness, efficiency and equity³⁵.” Unfortunately, these vital objectives have suffered from a lack of government funding and perennial violence.

Although ending the conflict is a prerequisite for addressing long-term health and food insecurity in South Sudan, peace on its own will not deliver necessary health sector reforms nor can health reform be expected to be a top-down, linear process of sweeping change. At the same time, international humanitarian actors cannot renounce their obligation to work with the government and other local authorities. It is imperative that humanitarian actors work to support existing systems as a means to ensure that interventions are sustainable.

In the short-term, CARE believes there are four key actions that donors and international humanitarian actors can take to invest in the foundations of community stability

while also addressing the immediate and prolific health and nutritional needs of the South Sudanese people. These actions, outlined below, capitalize on existing strengths – by working closely with the county health departments and communities to save the greatest number of lives now and into the future.

1. Enhance the Decision Making Power of Local Health Care Providers

“We are running at the pace of donors at the expense of beneficiaries. We need to go on our knees and begin from there.” – NGO staff member

The MoH Health Sector Development Plan reflects international best practice and outlines objectives and standards that would greatly improve the health system. Unfortunately, South Sudan is not in a position to fulfill these goals in the foreseeable future. In particular, objectives reflect an over-emphasis on the **structure** of the health care system, including infrastructure, tools, technology and staffing type and numbers. This is often in contrast to the **process** of care giving. Structural standards can be easier to observe and control and thus constitute a popular mechanism for assessment and accountability in developing countries. However, contrary to expectation, there is only a weak link between structural indicators and improved health outcomes, with the exception of standards which enhance access or increase a vital procedure³⁶. In the absence of the necessary financial



resources to 'modernize' PHC delivery and accommodate out-of-reach structural standards, supporting current staff in the delivery of care offers an efficient and effective means of improving PHC services. To do so donors, IPs, and the national and state MoH must enhance local decision making space in three ways.

SUPPORT LOCAL HUMAN RESOURCES (HR) AND HR MANAGEMENT

Healthcare administrators, the MoH, and sometimes NGOs attribute South Sudan's low health indicators to a "lack of capacity" or incompetence among healthcare staff and administrators, often obscuring solutions more adequately and sustainably resolved with their constructive engagement. CARE has found healthcare staff to be dedicated to their community. They provide valuable PHC services even when the situation is less than ideal, such as when a rush of battle-wounded soldiers crowd facilities that lack antiseptic. They can contain an outbreak of measles in the absence of drugs. They attend a night birth, flashlight in hand. They can establish services for their community when they are forced to flee as IDPs themselves. They often perform these vital services in the absence of salaries.

At the expense of investing in existing staff or allowing local administrators greater authority to determine context-appropriate staffing, the MoH enforces standardized personnel levels. As a midwife in Agok explained, "officials at the MoH are always calling for more midwives, that we shouldn't use TBAs. Where do they think they will get midwives from if they aren't training them?"

The reality today is that of the births that occur in facilities, only 15 percent are attended by what the MoH defines as "skilled" personnel – a doctor, clinical officer (CO), or certified midwife³⁷. It is community midwives and TBAs who together attend approximately 55 percent of all births³⁸. While recognizing the validity of MoH concerns regarding the dangers of an overreliance on untrained birth attendants, in the absence of alternative care providers they not only save lives but provide a crucial link between women and governmental facilities.

Community midwives and TBAs are not the only ones feeling pressure. According to 2011 MoH human resource policies, formal governmental training programs for CHWs and MCHWs were discontinued despite being a significant source of staffing. In 2011, there were

4212 CHW registered in South Sudan, representing 55 percent of all health facility staff across the country³⁹. Given the resultant gaps these policies imply, CARE believes the MoH and its partners should formally allow local healthcare managers and county health directors to design interim staffing measures to meet pressing healthcare needs while systematically addressing the longer-term skill requirements with both on-the-job training and an expansion of educational opportunities.

With the influx of IDPs, the Payam of Wau Shilluk (Malakal, Upper Nile State) is estimated to have doubled in size. There is one community midwife and only four TBAs. However, the PHCU does not work with TBAs as they are below the staffing standards set by the MoH. As TBAs are not on government payroll, they volunteer their services and work in women's homes. In a country where one in seven mothers will die in childbirth, the denial of the value of TBAs, the lack of support and training they receive, and their lack of access to facilities has potentially dangerous consequences. Among other things, TBAs are valuable in identifying and referring complications, ensuring cleanliness of delivery, promoting breastfeeding, and providing information⁴⁰. While WHO and UNICEF guidelines highlight the danger of TBA reliance due to their lack of medical training, their connection with pregnant mothers and presence at birth in the absence of alternative providers constitutes an opportunity to access a vulnerable group of women in the community in need of greater services.

SUPPORT STAFF INVOLVEMENT IN DRUG PROCUREMENT

Drug policies can also be incommensurate with realities on the ground. For example, consignments for health care facilities in USAID-supported states included 120 items, far more than the package of 15 drugs plus items distributed in IMA-supported states. The balance is largely composed of drugs for conditions that health practitioners are neither accustomed to diagnosing or treating. Drugs may go to waste; at worst they will be administered incorrectly. Further, while these ambitious consignments were procured at great cost, some areas of the country, including Jonglei and Upper Nile, face severe shortages of essential medicines, including malaria medication and antibiotics.

Drug supply issues need prioritization. Shortages not only threaten the health and well-being of the community, but erode communities' trust in and utilization of facilities. Informants mentioned the lack of drugs as a primary reason for reduced patient visits.

This is compounded by the frequent conflation of health care with drug provision and the perception of health staff as merely experts in drug dispensation. As one county official explained, without drugs there should be no health facility as “paying staff just pays one person. I don’t see the value in the facility being opened to merely add a few salaries to the community.”

Some drug shortages can be attributed to issues of inaccessibility and insecurity, yet many started before the crisis began. One reason given for recent delays is the inoperability of the “pull” system in some areas of the country. Instituted in February 2013, instead of receiving a standard package every quarter (“push” system), health facilities were to request required drugs based on consumption and predicted quarterly need. However, pre-existing problems such as a lack of electricity or internet and weaknesses in data collection and inventory management were not addressed in many locations, and little training and guidance was provided to new staff on how to utilize the system. CARE believes that this must be rectified. Further, experts argue that a “push” system is more efficient in emergency environments⁴¹.

In the short-term, it should be reinstated in the areas where the ‘pull system’ is not operational and enhanced with supplementary drug provision, outside of “regular” consignments; local health providers should be able to make drug requests utilizing consultation, the District Health Information Software (DHIS), and revised population indicators that reflect both the loss of population and the presence of IDPs. This would fulfill the objectives of increasing the decision space that local providers and administrators have over healthcare provision and ensuring that drugs reflect need while concurrently maintaining essential drugs supplies if this system were to face difficulties.

SUPPORT INFORMATION EXCHANGE WITH LOCAL HEALTH WORKERS

For the majority of local staff, their only communication with healthcare administrators is one-way, through weekly or monthly Health Management Information System (HMIS) reporting. One well-versed informant noted that South Sudanese reporting rates are very high, returning a weekly rate of 50-60 percent during the conflict, whereas other developing countries average rates as low as 4 percent. According to interviews with staff, HMIS and DHIS are considered valuable tools, yet they remain frustrated by the lack

of feedback they receive on reports as well as their inability to engage with higher authorities on the issues revealed.

The conflict has exposed how critical dialogue with local workers is while underscoring the danger of its neglect. Following an outbreak of measles in one payam in March, local health staff quickly produced and relayed information to relevant authorities. They only knew that the report was received when three months later a team of state-level health providers was sent in. By that time, up to 200 children had already died of the disease in only two bomas. Not engaging healthcare providers in decision-making, informing them of action to be taken, or providing a means for them to address their concerns is a missed opportunity to jointly strategize addressing community health needs.

NGOs and the national and state MoH must also work with county and local healthcare actors to collaboratively evaluate process indicators of care giving. In addition to prioritizing a participatory approach to healthcare administration and governance, mechanisms such as the balanced scorecard could more adequately assess local staff engagement in the healthcare process while providing opportunities to share local experiences, knowledge and needs. This will not only improve healthcare services, but can increase the speed with which decisions reach patients, offer the local health system as a forum where community opinions can be addressed and accounted for, and be a means to foster innovation, one of the key components of a well-functioning health system⁴². Significantly, a strong local health system with greater local buy-in can also be a source of stability and security, itself a crucial means of promoting positive health outcomes.⁴³

2. Integrate Nutritional Programming within the Local Health System

“Having many babies is dangerous for me. Even to feed them is a problem....I am too skinny now. When I give birth [in September] there will be no food. We will have run out.”

– ANC Patient

Health workers mention frustration that they are able to diagnose and treat an illness but that the patient’s health will remain in jeopardy until she or he is adequately fed. Children are particularly vulnerable to malnutrition-influenced cyclical illness. The WHO

estimates that acute malnutrition is an underlying cause in nearly half of all deaths for children under 5, and that in emergencies the greatest source of fatalities are children who are recorded as having died as a result of malnutrition or malnutrition-exacerbated illness⁴⁴. Many infections or diseases that might otherwise be treated successfully can result in fatality if a child is not sufficiently nourished. What is more, maternal nutrition has a significant impact on childhood disease. UNICEF found that at least 20 percent of the burden of disease among children under five is associated with maternal health and nutrition in addition to delivery and neonatal care⁴⁵.

Despite significant linkages, nutritional programs are not well integrated into the existing health infrastructure in South Sudan. While they are a part of the basic package of primary health, in fact, there are no curative nutritional programs within the health services originally designed under the three funding mechanisms (World Bank, HPF and USAID) currently operating⁴⁶. Though limited emergency funding diversions have been made available to help fill this gap more often health and nutrition programs are parallel-served through different funding streams, partners, and staff and coordinated groups.

Health providers should see nutrition as an integral element of their routine work through the long-term. Interviewed staff spoke of their ability and desire to do nutritional screening but claimed they were not doing so as it was under the purview of different nutrition-focused NGOs, was not part of their expected tasks, or because they were not given the supplies necessary to treat malnutrition if identified. This lack of integration is problematic for a number of reasons. First, health care practitioners are best qualified to identify and treat malnutrition. This is all the more important in light of studies demonstrating that, in addition to the provision of specialized foods, uncomplicated SAM treatment could improve with additional medical interventions employed at the community level⁴⁷.

Second, data collection suffers from a lack of coordination between nutrition and health actors. For example, while children reaching a health facility are treated for the most manifest health concern, whether malaria, diarrhea or other, malnutrition is often an underlying cause but remains unreported in health surveillance data, potentially leading to both underestimates of malnutrition and failures to appropriately treat it.

Third, mothers are reportedly far more likely to attend a feeding center distributing plumpy nut, a supplement given to children and pregnant women who are malnourished, than they are to attend a clinic. Having trained health staff present is an opportunity to examine children and caregivers to diagnose other illness that patients exhibit. In light of their interconnections, it is all the more crucial that the health causes and manifestations of malnutrition are treated concurrently.



Aamira

Due to temporary displacement because of insecurity, Aamira's family of 12, including 8 children, five of which are her own, only planted a small garden this year. They also recently lost their cows to a raid. Worried about hunger, four months ago Aamira decided to borrow a small amount of money and open a tea shop. She only earns about \$3 to \$5 USD a day, but now everyone in the family can have one meal daily, mainly of sorghum. While others in the community might be migrating to Ethiopia and elsewhere in search of food, Aamira and her family will stay because they simply have too many children to make the long journey.

"Our situation is deteriorating and no one cares about us, but if people knew the situation here...."

Her sentence drops off, simply because she is so tired. The clinical officer translating this conversation decides to make a diagnosis. Aamira has malaria and anemia, as do other family members of hers sharing the same symptoms. She can receive treatment, but will likely get sick again unless she is able to find more to eat.



Mary

Mary is about to give birth to her sixth child. Due to the insecurity in the town in which she lived, she moved an hour away making the health facility less accessible. She will not give birth in a facility or with a birth attendant and therefore, over the course of her pregnancy her only interaction with health personnel will be her ANC visits, which she hopes she can continue despite the distance. Unfortunately, the clinic is not positioned to offer her nutritional support during her pregnancy or in a month, when she is lactating. If services were integrated, the chances of being identified as in need of nutritional services would be high and she might be able to receive the support necessary to guarantee her life and that of her child. Without such support, not only her health but the health of her future child could be in jeopardy.

Fourth, many parents bring one or two of their children showing signs of malnourishment to a screening but, upon returning home, distribute plumpy nut to all of their children, jeopardizing the health of the malnourished child. The presence of a healthcare worker could lend legitimacy to supplements as prescribed treatments. Finally, combining health and nutrition services, particularly during outreach, could engender a more sustained and holistic relationship between health staff and families. This is especially important in South Sudan. While the conflict has greatly exacerbated malnutrition, unacceptably high rates existed prior, speaking to their structural nature. Unfortunately, most methods of tackling this problem revolve around short-term humanitarian assistance interventions.

3. Enhance Community Outreach

“After I graduated I went to work in the field. I came to be the change in the community, but the community changed me.” –Clinical Officer

In South Sudan the health concerns that cause the greatest mortality and morbidity generally and in crises are preventable illnesses exacerbated by food insecurity. These are conditions that can be identified by outreach workers who visit individuals

otherwise less likely to consult a provider. Behavioral interventions, preventative care, such as Vitamin A supplementation, and minor curative interventions, such as deworming, can also be conducted for those with less accessibility to clinics. Further, patients are also more likely to proactively visit health care facilities if providers cultivate relationships, ensuring cultural appropriateness of care, and sensitivity to gender⁴⁸. Trained outreach workers are often drawn from the communities they serve and are more likely to be able to identify needs and foster trust. Additionally, they are able to reach out to patients to monitor their progress, a significant service in environments of food insecurity where recurrent illness becomes more prevalent. Unfortunately, following the outbreak of violence in South Sudan, when facility visits have declined and more outreach is needed, respondents note a decrease in outreach services due to funding constraints, the inoperability in some areas of healthcare administration, the loss of healthcare workers, and the redirection of efforts thought more “emergency” in nature.

WOMEN’S ACCESS TO HEALTH SERVICES

Women face specific barriers when accessing health services; outreach services are particularly well-suited for serving women.

- Greater healthcare needs. In South Sudan, about 196,000 women are pregnant at any given time, all of whom require care to ensure safe pregnancies and deliveries⁴⁹. Further, in crisis settings, life-threatening pregnancy complications requiring emergency care will affect an estimated 15 percent of pregnancies and between 9 and 15 percent of newborns will require emergency care⁵⁰. Food insecurity further heightens health risks for pregnant women and newborns. Additionally, the UN has estimated that 24,000 women are at risk of sexual violence in South Sudan, which can result in a litany of health concerns.
- Distance to healthcare facilities. While the MoH has tried to ensure that every family has a healthcare facility within a two-hour walk, this is rarely achieved, particularly in the rainy season where accessibility can become challenging. As caregivers, women might also have the burden of carrying children, have limited mobility when pregnant, and might have greater concerns about the security of travel.
- Resources. Women are less likely to have access to household resources required for healthcare and are more likely to defer spending on healthcare for themselves. One midwife recounted the story of a gravely ill woman requiring costly medical interventions to save her life. When her husband was advised to sell a cow to pay for treatment he refused explaining that he had other wives but each cow was indispensable. While this example is unrepresentative of all South Sudanese household spending priorities, it reflects the general sense among practitioners that women's health concerns are given low priority.
- Maintaining the household. Particularly in areas with high levels of food insecurity, many women spend time procuring and cooking uncommon foods such as un-ripened maize or gathered foods. Similarly, many women have resorted to collecting grass and firewood to earn money to supplement income. Time constraints can be burdensome and CARE research found that some mothers simply lack the time to take their children or themselves to the clinic, even when they recognize the need for medical care.
- Sensitivity. Some female informants have mentioned their discomfort at attending a facility with little privacy and no female staff. Further, some of the medical concerns that women might have, including sexually-transmitted diseases or complications from

sexual violence, are extremely sensitive issues that require trained personnel to identify in private consultation with patients.

Notable best practice in enhancing community outreach is the integrated Community Case Management (iCCM) approach. This is valuable in contexts of isolated and or disrupted access to static health facilities. Within this, community volunteers are trained to identify common childhood illnesses (malaria, diarrhea, ARI) and provide basic drugs. This should be integrated with greater support for nutrition, SRMH, and SGBV services and referral mechanisms.

4. Support Mechanisms for Greater Community Involvement in the Healthcare System

“Let the community contribute, let them be part of the solution. Let us use this opportunity to see what communities can do.”

– Community Health Worker

At present, community members are overwhelmingly disempowered in the healthcare system. Staff and administrators reinforce their exclusion, sometimes describing beneficiaries as uneducated, disinterested in involvement and bound by ‘culture.’ In reality, there is no shortage of concerned, motivated citizens. Research demonstrates that health governance and service delivery can be improved by strengthening the participation of community members, local officials and civil society groups⁵¹. In particular, inclusive civil society engagement is an important means of mobilizing support for health goals, enabling beneficiaries to concerns and holding accountable both healthcare providers and relevant local authorities. Unfortunately, by ignoring solutions that come from the community we are failing to capitalize on our greatest capacity: community members themselves and their willingness to lend ideas, labor and commitment.

As a means to leverage the community, CARE believes that Village Health Committees (VHCs) must be strengthened. This is not a new recommendation and echoes MoH proposals for a greater role for VHCs in healthcare provision. However, implementation has lagged, partly because local level participatory engagement initiatives are seen as unsuitable in emergency environments. Yet, it is specifically in such environments that their worth can be most easily demonstrated.

Ker

Ker is a boy of about nine or ten, his mother cannot remember. Maybe it's because she is distracted. She has a child with a developmental disease, a baby suffering malnutrition, another with AWD, and a large family to feed without money, crops or cattle, only a handmade spear that her young boys use for fishing. Neighbors cannot help because these days, **"life is the same for everyone; there is nothing."** If the family eats, it is once a day in the morning, and Ker's mother worries all day about finding food for their next meal. While she noticed that Ker had scraped his legs, she did not notice how badly his infection had become and how Ker was finding it painful to walk. The CARE clinical officer visiting her home was able to diagnose Ker's infection, prescribe treatment and convince Ker to accompany him to the health facility where they were able to clean his wound and provide the necessary medications. Without the visit, Ker would have likely required more intense and expensive treatments to save his leg.



Recently, following an influx of combat-related injuries, the VHC at one CARE-supported clinic decided to build a fence to protect quality of care without the interruption of the crowd. In another community undergoing a mass causality incident, the VHC cleaned a facility with boiled water in the absence of soap. Healthcare administrators also recounted examples where a VHC was responsible for establishing referral services and in another where they facilitated dialogue between community members and healthcare staff, dispelling rumors. Where VHCs are operating and representative of communities, afforded clear roles and responsibilities, provided resources and empowered to affect change they can influence the healthcare system to meet local needs, saving lives in the wake of conflict and contributing to facility stability over time.

Allowing the community to express their needs in a fashion that formalizes accountability mechanisms to the officials who serve them could help improve health services. Among others, models shown to be effective at increasing community involvement in accountability mechanisms for improved healthcare outcomes include Citizen Voice and Action (World Vision), Partnership Defined Quality (Save the Children), and the Community Score Card (CARE)⁵². While social accountability mechanisms need enabling environments and willing participants, and in South Sudan reflect a medium-term objective, operationalizing elements of these modes in conjunction with the VHC framework can set the ground for long-term initiatives.

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Recommendations

1. Enhance the Decision Making Powers of Local Health Care Providers.

Donors:

- a. While funding humanitarian programming, **should ensure that partners help build or maintain underlying institutions.** In the health sector there is a tendency to fund vertical programs targeting specific diseases as discrete projects. While this can facilitate monitoring and evaluation, it is necessary to invest greater funds in local capacity building (including training programs as well as systemic governance initiatives), health worker salaries and facility infrastructure.
- b. Work with implementing partners and the MoH to **deliver standard PHCC and PHCU consignment packages that successfully address the greatest causes of mortality in conflict**, primary health and nutrition. Consignments should ensure equity across the country accounting for per-person served, differential costs of provision in remote areas, localized needs and the heightened logistics costs of difficult to access areas. Further, provisions must be made to account for conflict-specific health determinants including SGBV and mental health needs.

The Ministry of Health (with support from relevant UN agencies), Fund Managers and Implementing Partners:

- a. Work with local and county officials to **develop a system of graduated or tiered standard setting** that allows local facilities to measure their attainment against feasible criteria, making goals within reach and accountability mechanisms functional.
- b. **Enhance the decision-making space of local healthcare workers and administrators** by providing the training, knowledge and support required for the delegation of responsibilities including those regarding context-appropriate staffing and drug supply. Further, enhance mechanisms for empowered local dialogue and information sharing across hierarchical levels.
- c. **Define interim staffing measures which allow for “risk allowances” in emergency settings** to meet pressing healthcare needs, including training present staff members to obtain higher levels of certification on-the-job while systematically addressing the longer-term skill requirements. A particular focus should be on ensuring that TBAs are integrated into the health care system.

2. Integrate Nutritional Programming within the Local Health System.

Donors:

- a. Donors should **prioritize comprehensive, multisectoral interventions** recognizing the inextricable linkages between health, nutrition, food security and livelihoods and water, sanitation and hygiene.
- b. **Support the integration of nutritional programming into healthcare provision.** Integration would greatly enhance community health by better managing malnutrition, ensuring identification and treatment of its complications and incentivizing parents to bring children to healthcare centers.



3. Enhance Community Outreach and Create Mechanisms for Greater Community Involvement in the Healthcare System

Donors:

- a. **Increase levels of long-term** assistance to maintain resilience, particularly in light of the potential for greater instability and escalating food insecurity in coming months. Staving off an even greater humanitarian crisis will require substantive additional attention to those areas of the county that do not currently face high levels of combat-related violence but that are nonetheless affected.
- b. Humanitarian initiatives should **support outreach services and community engagement**. While not traditionally an integral aspect of humanitarian program portfolios, these initiatives can foster effective service delivery during an emergency while also contributing to development gains.
- c. **Implement commitments from the Call to Action on Violence against Women and Girls (VAWG) in Emergencies**. All humanitarian programs should support the active and meaningful participation of women and girls, include partnerships with civil society groups that advocate for women and promote collaboration across local, national, regional and international scales. All interventions should be designed to promote gender equity and equality.

The Ministry of Health (with support from relevant UN agencies), Fund Managers and Implementing Partners:

- a. **Train all outreach officers to offer basic SRMH services and to refer women in need of specialized care**. More attention must be given to gender sensitivity, training female outreach workers, and training outreach workers to meet women's particularly health needs. Further, to increase access to care, develop alternative mechanisms of service delivery, such as 'roving' midwives and obstetricians, outreach and of referral (including bicycle, motor-bike and porter-carried stretch transportation coordinated through radio and cell phone communications).
- b. **Support the development of VHCs**. Techniques such as the balanced scorecard approach could more adequately assess the community's role in the health care process while providing them with opportunities to share their experiences, knowledge and needs.

In Support of These Efforts Parties to the South Sudan Conflict and International Political Actors Should Ensure:

- a. Greater political will and attendant funding is galvanized **to enact mechanisms for holding to account those who target civilian and humanitarian objects and staff**, including health services, facilities, transport, workers and patients.
- b. **An effective and resilient system is created that can address the PHC and nutrition concerns of the South Sudanese people, supported by an engaged and enabled civil society**. While legislation on security and non-governmental organizations is welcome, if not based on regional and international human rights law and international best practice, such legislation could threaten the nascent chances for development while precluding future opportunities for sustainable gains.





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NOTE: All personal names presented in this brief have been changed.