

# MOMENTUM

Integrated Health Resilience



## THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPN) AND APPLICATIONS TO FAMILY PLANNING, REPRODUCTIVE HEALTH, AND MATERNAL, NEWBORN, AND CHILD HEALTH (FP/RH/MNCH) INTERVENTIONS IN FRAGILE SETTINGS

### A Case Study from South Sudan

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## ACRONYMS

Acronym	Definition	Acronym	Definition
ANC	Antenatal Care	HPF	Health Pooled Fund
BEmONC	Basic Emergency Obstetric and Newborn Care	ICR	Indirect Cost Rates
BHI	Boma Health Initiative	ICRC	International Committee of the Red Cross
BHW	Boma Health Worker	IDI	In-depth Interview
BPHNS	Basic Package of Health and Nutrition Services	ILO	International Labour Organization
CHH	Johns Hopkins Center for Humanitarian Health	INGO	International non-governmental organization
COVID-19	Coronavirus Disease	INTPA	Directorate-General for International Partnerships (European Union)
CRW	Crisis Response Window	IP	Implementing Partner
CYP	Couple-Years of Protection	IPC	Integrated Food Security Phase Classification
DHIS2	District Health Information System 2	IRB	Institutional Review Board
DSRSG/RC/HC	Deputy Special Representative of the Secretary General, Resident/Humanitarian Coordinator	KII	Key Informant Interview
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations	LARC	Long-Acting, Reversible Contraceptive
EmONC	Emergency Obstetric and Newborn Care	LMICs	Low- and Middle-Income Countries
EP&R	Emergency Preparedness & Response	LNGO	Local Non-Governmental Organization
EPI	Expanded Program on Immunization	MIHR	MOMENTUM Integrated Health Resilience
ERRM	Emergency Rapid Response Mechanism	MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations
EU	European Union	MNCH	Maternal, Child, and Neonatal Health
FCDO	UK Foreign, Commonwealth & Development Office	MOH	Ministry of Health
FP	Family Planning (voluntary)	MoHEST	Ministry of Higher Education, Science and Technology
HCW	Health Care Worker	MSF	Médecins Sans Frontières
HDN	Humanitarian-Development Nexus		
HDpN	Humanitarian-Development-peace Nexus	NGO	Non-Governmental Organization
NICRA	Negotiated Indirect Cost Rate Agreement	OCHA	UN Office for the Coordination of Humanitarian Affairs

<b>Acronym</b>	<b>Definition</b>	<b>Acronym</b>	<b>Definition</b>
NNGO	National Non-Governmental Organization	NICRA	Negotiated Indirect Cost Rate Agreement
NNGO	National Non-Governmental Organization	SHTP	Sudan Health Transformation Project
OCHA	UN Office for the Coordination of Humanitarian Affairs	SRH	Sexual and Reproductive Health
ODA	Official Development Assistance	SRHR	Sexual and Reproductive Health and Rights
OECD	Organization for Economic Cooperation and Development	SSHF	South Sudan Humanitarian Fund
PfRR	Partnership for Resilience and Recovery	STI	Sexually Transmitted Infection
PNC	Postnatal Care	TB	Tuberculosis
PHCC	Primary Health Care Center	UN	United Nations
PHCU	Primary Health Care Unit	UNFPA	UN Population Fund
PSC	Program Support Costs	UNHCR	UN High Commissioner of Refugees
RAG	Resilience Advisory Group	UNICEF	UN Children's Fund
RH	Reproductive Health	USAID	United States Agency for International Development
RRC	Relief and Rehabilitation Commission	WASH	Water, Sanitation and Hygiene
RRF	Rapid Response Fund	WB	World Bank
RRT	Rapid Response Team	WFP	World Food Program
SDG	Sustainable Development Goals	WHO	World Health Organization
SGBV	Sexual and Gender-Based Violence		

## EXECUTIVE SUMMARY

MOMENTUM Integrated Health Resilience (MIHR), funded by USAID, explored the humanitarian-development-peace nexus (HDpN) for family planning, reproductive health, and maternal, newborn, and child health (FP/RH/MNCH) interventions in South Sudan. The HDpN refers to the intersection and integration of humanitarian, development, and peace activities, and is necessary for the planning, provision, and use of health services to those who are affected by crises. The study involved document reviews along with key informant and group in-depth interviews with numerous stakeholders, revealing challenges within the HDpN due to fragmented leadership, complex funding landscapes, and inadequate coordination mechanisms.

South Sudan has an extensive history of violence and conflict, which has continued into its post-independence era, making the health system weak and fragile. Furthermore, sanctions and transparency has complicated the provision of funding to the government. The Ministry of Health (MOH) of South Sudan is currently the leading entity guiding national and sub-national health policy and strategy in principle, however, the health system itself is decentralized and divided into different administrative units. Humanitarian and development interventions in the country often deviate from traditional approaches, with development funding primarily supporting lifesaving interventions (which are often supported by humanitarian funding in other countries) due to ongoing conflict, hindering investment in health system strengthening. Both historically and today, investment in health system strengthening and resilience has been considered impracticable in South Sudan due to the absence of peace, which is considered a barrier to sustainable development. The complex institutional structure and ongoing conflict present significant barriers to implementing meaningful change and integrating humanitarian and development efforts effectively. These barriers were openly discussed among most case study participants, yet this reality continues to prevent systematic change in the South Sudan.

The conceptual framework leveraged in this case study examined several core pillars of the HDpN including leadership, finance, coordination, preparedness and planning, and information management. The first three pillars emerged as key concepts, in addition to several others including health service provision and providers, localization, and sustainability, resilience, and durable solutions. Findings from each thematic area were presented, in addition to recommendations which were then assigned to one or more target stakeholders.

In South Sudan, challenges in health governance and leadership structures arise from the large majority of funding channeled through UN agencies and international NGOs, hindering the MOH's ability to assert leadership over health services. Silos between humanitarian/development actors and the MOH exacerbate sustainability issues within the health system. The complex funding landscape, with separate streams for humanitarian and development aid, alongside recent cuts in development funding leading to service interruptions, underscores the need for closer collaboration between development and humanitarian actors to address health challenges sustainably. Additionally, fragmented humanitarian and development coordination mechanisms and challenges in field-level coordination hinder efficient resource allocation and delivery of health interventions. Addressing these challenges is crucial for achieving the Sustainable Development Goals (SDGs), especially considering the country's high maternal mortality ratio and low contraceptive prevalence rate.

Despite efforts by the government and UN agencies to increase FP uptake, challenges persist due to cultural barriers, limited funding, and competing health priorities, underscoring the need for sustained investment and community engagement to overcome these obstacles and improve maternal and reproductive health outcomes. Additionally, establishing and maintaining a competent local healthcare workforce is crucial for the success of the health care system. However, achieving this in South Sudan has been limited due to several factors including limited resources for training, violence towards healthcare workers, needs of international agencies, and compensation disparities. The COVID-19 pandemic highlighted the urgency of localizing humanitarian efforts in fragile states like South Sudan, necessitating community-centered approaches, enhanced institutional capacities, and direct funding streams to address shocks including the pandemic and recurrent flooding. Interviews emphasized the critical need for sustainability, resilience, and durable solutions in South Sudan's health interventions, calling for collaboration with government technocrats, community involvement, and grassroots investment to move towards long-term development and away from dependency on humanitarian aid.

Key recommendations include enhancing FP services and promoting self-care interventions for sexual and reproductive health (SRH), scaling up programs, improving human resource strategies, rationalizing maternal and child health/SRH services, addressing barriers to the HDpN at the institutional level, increasing government ownership for sustainability, consolidating development funding mechanisms, ensuring planned transition strategies for short term humanitarian funding and longer-term development funding and programming at the state level, investing in additional preparedness planning, eliminating redundancies in coordination bodies, establishing a comprehensive mapping system for roles and responsibilities of humanitarian and development actors, accelerating localization commitments, ensuring meaningful engagement and support for national/local NGOs in capacity strengthening activities, and enhancing measures for sustainability, resilience, and durable solutions tailored to the South Sudan context.

Limitations of the project considered issues of various forms of bias (selection, recall, and implicit), sampling issues, as well as the broad nature of the HDpN and its application to RH/MNCH/family planning as there are many other critical issues currently faced by South Sudan. In summary, this case study delved into the intricacies of implementing humanitarian and development interventions in South Sudan, a fragile and dynamic context marked by ongoing conflict and political instability. Despite some efforts to bridge the HDpN, challenges persist due to chronic insecurity and limited progress in recovery and development. The healthcare landscape, particularly for FP/RH, is hindered by operational complexities and institutional barriers. FP is identified as a crucial intervention linked to the SDGs and maternal health outcomes, yet faces obstacles in implementation and uptake. Action by and between humanitarian and development actors remains fragmented, necessitating consolidation and establishment of dedicated coordination mechanisms. Human resource management and supply chain efficiency are highlighted as critical areas requiring attention for sustainable health systems. Additionally, there is a call for rationalization of interventions and integration of FP initiatives within broader healthcare services to enhance sustainability. Donors are urged to align efforts with government priorities and community needs, focusing on health system preparedness and resilience to address the unique challenges faced in South Sudan.

## INTRODUCTION

This report examines the humanitarian-development nexus (HDN) and its application to health interventions in South Sudan, specifically family planning, reproductive health, and maternal, newborn, and child health (FP/RH/MNCH). Humanitarian assistance is lifesaving and works to “alleviate suffering and maintain human dignity during and after man-made crises and disasters caused by natural hazards, as well as to prevent and strengthen preparedness for when such situations occur” [1]. It is governed by the four key principles of humanity, impartiality, independence, and neutrality [1]. Development assistance is defined as aid from foreign governments that “promotes and specifically targets the economic development and welfare of developing countries” [2]. The Sustainable Development Goals highlight three key elements: economic growth, social inclusion, and environmental protection [3]. **Table 1** below summarizes other key distinguishing features of humanitarian and development assistance [5]. This report applies these definitions, specifically in health and FP/RH/MNCH interventions.

Numerous approaches have been developed to define the HDN, also referred to throughout this report as “the nexus,” and more broadly, the humanitarian-development-peace nexus (HDpN). These concepts refer to the intersection and integration of humanitarian, development, and peace activities. In the landscape analysis and conceptual framework developed by the Johns Hopkins Center of Humanitarian Health (CHH) in 2021, the HDN has called for an “integrated and holistic focus [that] is necessary for the planning, provision, and use of health services to those who are disproportionately affected by crises” [6]. **Figure 1** depicts an expanded conceptual framework from the landscape analysis that illustrates the intersection of these concepts as they relate to the nexus, health service delivery, and improved health outcomes in fragile settings. The framework includes core pillars of the nexus along with vital considerations of contextualization, localization, quality, and other fundamental principles and norms [6]. Efforts to operationalize the nexus remain elusive. A broader understanding and translation of these concepts to more concrete and feasible interventions that can be documented with measurable outcomes is necessary. This is essential for the health sector, but more critically for FP/RH/MNCH services, given that women and children are disproportionately affected by crises and conflicts globally.

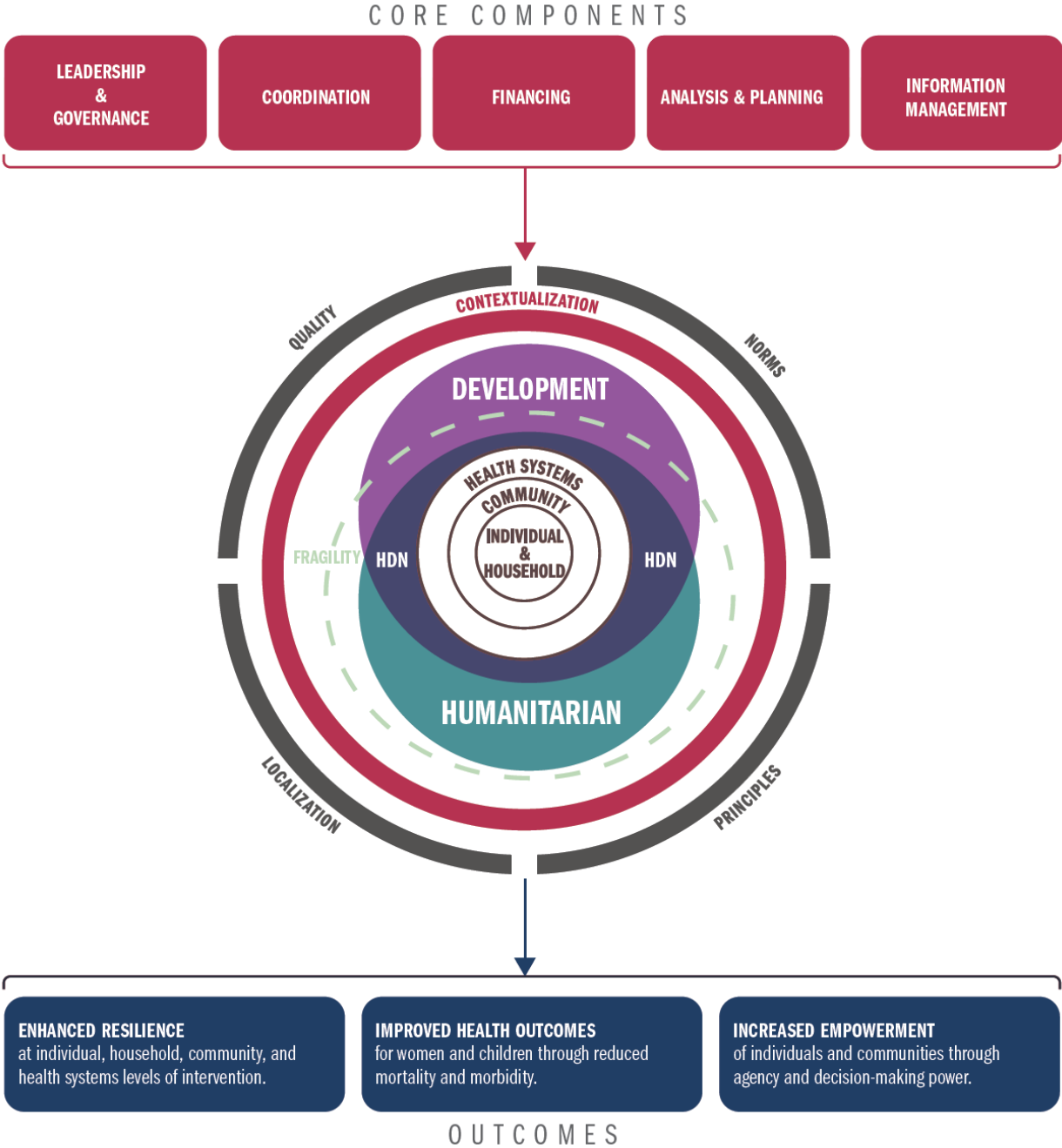
**Table 1. Distinguishing Features of Humanitarian versus Development Assistance**

	<b>Humanitarian</b>	<b>Development</b>
<b>Culture/Approach</b>	Substitution and Parallel	Complementary
<b>Timeline (on average)</b>	6-12 Months; 2 Years (Multi-Year Emergency Awards)	5-10 Years
<b>Coordination/Leadership</b>	System-led; clusters and sectors	Government-led; International Health Partnerships and related initiatives (IHP+); Universal Health Coverage (UHC)
<b>Planning Frameworks and Tools</b>	Humanitarian Response Plan (HRP); Refugee Response Plan (RRP)	United Nations Development Assistance Framework (UNDAF); Common Country Analysis (CCA); National Health Plan (NHP)
<b>Legal Frameworks</b>	Humanitarian Principles	Sovereign law



	<b>Humanitarian</b>	<b>Development</b>
	International Humanitarian Law	Aid effectiveness principles
<b>Types of Settings</b>	Fragile and insecure	Stable and willing

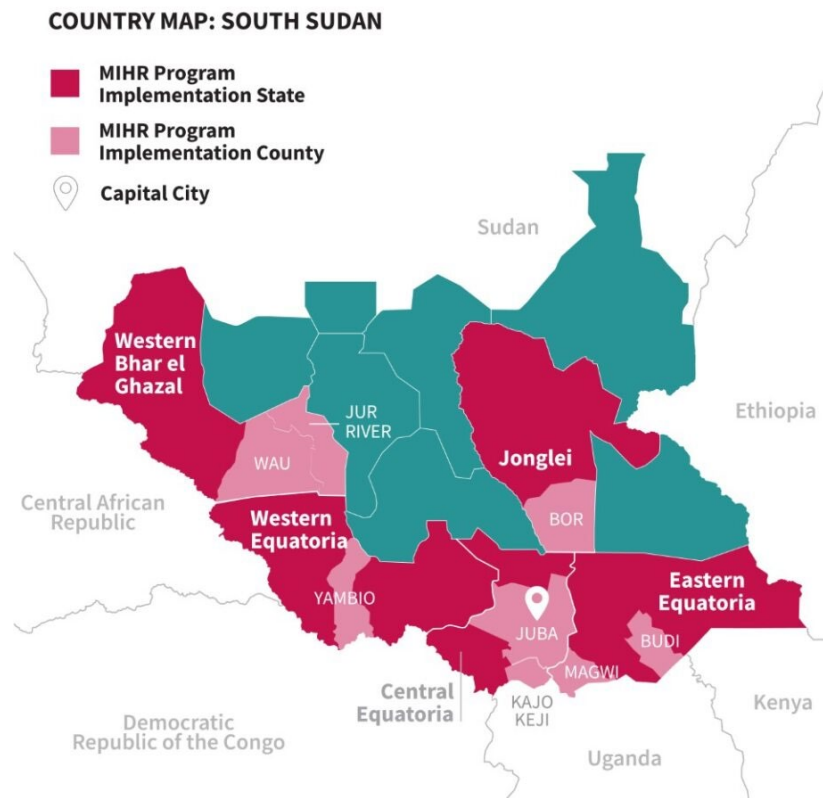
**Figure 1. Conceptual Framework of HDN and Health Interventions in Fragile Settings**



## BACKGROUND AND HEALTH SECTOR OVERVIEW

South Sudan declared independence on July 9, 2011, following decades of conflict during the First and Second Sudanese Civil Wars [7], [8]. Prior to independence, a Comprehensive Peace Agreement was put in place, establishing South Sudan's autonomy [9]. The country comprises ten states, including the Equatorias (Western, Central, Eastern), Northern and Western Bahr El-Ghazal, Unity, Jonglei, Upper Nile, Lakes, and Warrap [10]. Additionally, there are three administrative areas of Abyei, Ruweng, and Pibor [11]. See **Figure 2**.

**Figure 2. South Sudan and Neighboring Countries Map**



South Sudan's Transitional Constitution has guided the national government, which outlines a decentralized model in theory [12]. In practice, however, government authority is centralized, as power is primarily concentrated at the federal (i.e., Juba capital) level [13]. Below the federal level, the structure comprises the State, County, Payam, and Boma levels, with the Boma being the most basic administrative unit [14]. As it pertains to disaster relief, the Constitution outlines the government's formation of an independent commission called the Relief and Rehabilitation Commission (RRC), which is headquartered in Juba but has representation at state, county, and Payam levels [14], [15]. RRC operations are overseen by the Minister of Humanitarian Affairs and Disaster Management [15].

In 2013, soon after independence, the young country experienced civil war, as intermittent fighting erupted between the President and Vice President leading to broad offensives across the country and severe violence perpetrated against civilians [15], [16]. While mediation efforts have led to various

agreements to resolve the conflict and establish a transitional Unity Government between 2015 and 2020, full implementation of these accords has remained elusive, and the country continues to face serious challenges related to health, security, economic stability, and the political climate [16]. In 2005, a United Nations (UN) peacekeeping mission was established in Sudan (UNMIS) to support the implementation of the peace agreement [17]. In 2011, UNMIS ended its mandate, and a new UN peacekeeping mission was established for South Sudan (UNMISS), which continues its presence to this date [18], [19]. Post-conflict and peacebuilding efforts have been underway since the signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan was signed and since the formal establishment of the Transitional Government of National Unity in February 2020, which has been extended through 2025 to facilitate the government's fulfillment of various components of the agreement [19]. Ongoing conflict across many parts of the country has stemmed from intercommunal violence and community-based militias, with violence often provoked by cattle raids in agropastoral regions [20]. Security forces like the National Security Service have initiated crackdowns on dissenting civic action groups, media workers, protestors, and activists [20]. The Cabinet has moved forward with approving the establishment of a hybrid court, truth and reconciliation commission, and compensation and reparations authority according to the provisions of the 2018 agreement; however, these have not yet been realized [20].

The mode of operation in South Sudan has become increasingly complicated for the reasons above, in addition to other critical issues, including South Sudan ranking highest globally in terms of a lack of transparency [21], [22]. Issues of transparency, trust, and internal conflict within the government have led to sanctions of numerous senior officials in both government and the private sector in place since 2014/2015 by the UN and the United States government, among other stakeholders that have limited their engagement with the Government of South Sudan, specifically with individuals who have obstructed the peace agreement, have committed human rights abuses, or those involved with corruption [23]–[25]. The United States has extended previously enacted sanctions in light of “activities that threaten the peace, security, or stability of South Sudan and the surrounding region, including widespread violence and atrocities, human rights abuses, recruitment and use of child soldiers, attacks on peacekeepers, and obstruction of humanitarian operations” [24]. Targeted sanctions have remained in place since first imposed, and coupled with a lack of political will, have further complicated the ability to operate in South Sudan.

Concerns around nepotism and cronyism have emerged, as the President has been perceived to promote and publicly favor persons based on tribal or ethnic background, many of whom are under international sanctions or linked to crimes against civilians [20]. South Sudan can be categorized as a “non-permissive environment” according to USAID’s classification of contexts with stability, security, and safety constraints at national or sub-national levels [26]. USAID’s “Country Roadmap” for South Sudan ranks the country 108 in terms of fragility (out of 120), “high” in terms of external debt distress, and extremely low in terms of both capacity and commitment, where *capacity* is “the degree to which a country can manage its own political, social, and economic development including the ability to work across these sectors,” and *commitment* is “the degree to which a country’s laws, policies, actions, and informal governance mechanisms, such as cultures and norms, support development progress” [27]. The Country Roadmap was previously referred to as the “Journey to Self-Reliance” or J2SR, which entailed USAID’s approach for greater development outcomes and work toward the elimination of the need for foreign aid for recipient countries, as they worked toward greater self-

reliance [28]. See the full Roadmap in **Annex A**. USAID restrictions for paying government personnel, often termed “zero-cash” policies, coupled with the indirect effects of targeted sanctions, have had a critical impact on engagement with the government in South Sudan [29], [30].

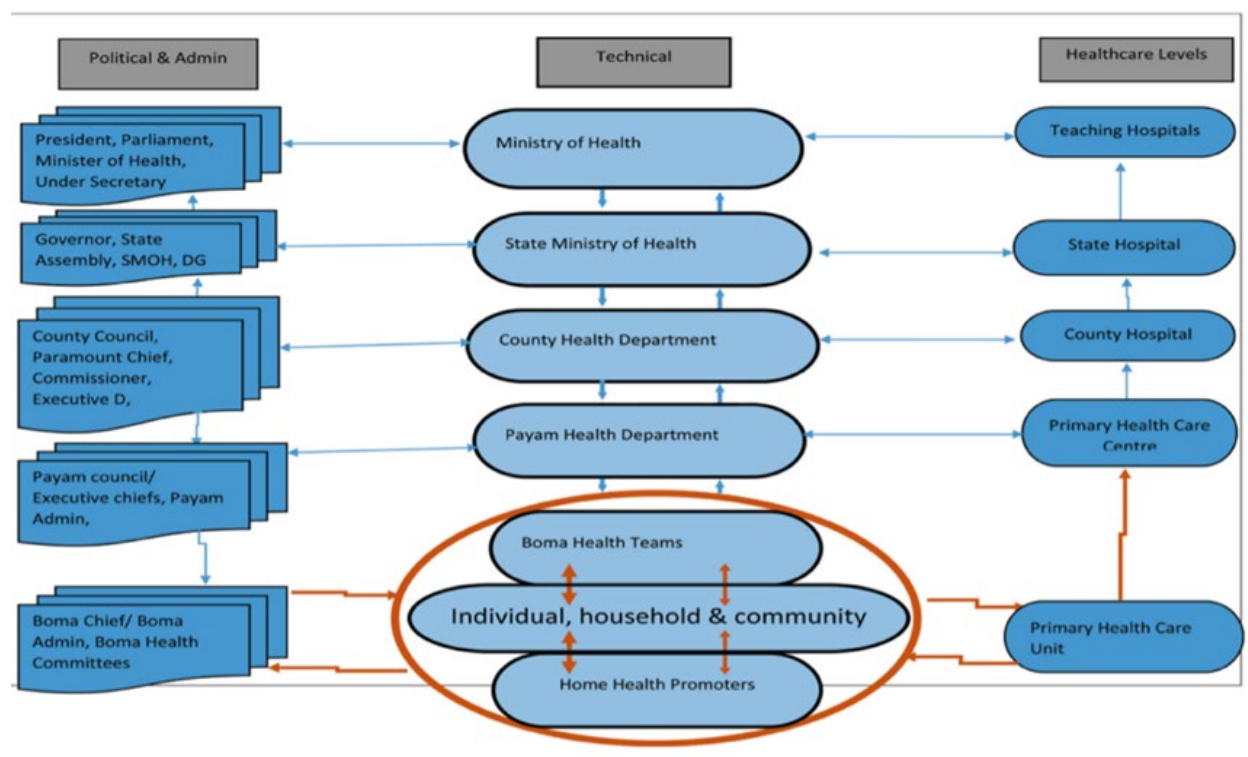
Even before the recurrent conflict in the post-independence era, South Sudan’s health system was weak and fragile, and its functioning has remained precarious [31]. This fragility has carried over from southern Sudan’s marginalization before independence, where much of the health infrastructure was damaged or destroyed because of the war along with a massive shortage of healthcare workers (HCWs) and only 16% of the 8 million people in the southern region able to access healthcare services in 2011 [32]. South Sudan has ranked among the highest in terms of violence towards health care workers and health facilities, with over 148 incidents documented within the first few months of 2023 [33], [34]. This has made it immensely challenging for the health system to meet the population's needs or basic service delivery standards, including inadequate staffing and quality care for a highly transient population, as there are over 2.3 million internally displaced and approximately 2.33 million people seeking refuge outside the country as of July 2023 [35], [36].

Climate-related shocks, particularly persistent floods and seasonal droughts, also pose an ongoing threat to the population's health, with high prevalence rates of endemic diseases. Less than half of the population receives full routine immunizations [37]–[39]. COVID-19 introduced an additional burden to the already-fragile health system, and the country is considered at a high risk for cross-border transmission of Ebola [37]. South Sudan is one of the world’s most food-insecure countries [40]–[42]. While humanitarian funding to South Sudan for 2023 has remained roughly the same according to the Humanitarian Response Plan (HRP), the needs continue to increase, with approximately 76% of the population in need of humanitarian assistance in 2023 (a 4% increase since 2022) [43], [44]. Key health demographics and population indicators are summarized in **Table 2** and a more comprehensive list of key demographic indicators is provided in **Annex B** [45]–[82].

## AN OVERVIEW OF HEALTH SECTOR POLICIES, PLANS, AND STRATEGIES

The Ministry of Health (MOH) of South Sudan is the lead entity guiding national and sub-national health policy and strategy. The health system is decentralized and divided into different administrative units overseen by the MOH and implemented by state-level ministries and county health departments [83]. **Figure 3** provides a depiction of all administrative units [84].

**Figure 3. Administrative Health Units of South Sudan**



**Table 2. Summary of Demographic Indicators in South Sudan and Global Averages**

Indicator	South Sudan	Global Average
Population, Total (2023, estimate)	12.1 million	---
Under 5 (U5) Mortality Rate (2021) (# of deaths per 1,000 live births)	90.7	38
Neonatal Mortality Rate (2021) (# of deaths per 1,000 live births)	40	18
Maternal Mortality Ratio (2020) (# of deaths per 100,000 live births)	1,223	223
Contraceptive Prevalence, any methods (2010) (% of women ages 15-49)	4	63
Acute Malnutrition Prevalence (2023) (estimated # of women and children)	2 million	57.9 million
Gender-Based Violence Risk (2022) (estimated # of people)	2.6 million	1.3 billion

The MOH has developed various guidance documents for the health sector that encompass various health topics [85]–[90]. These include the following:

- National Health Policy (2016-2026)
- Health Sector Development Plan (2012-2016)
- Reproductive Health Policy (2013)

- Reproductive Health Strategic Plan (2018-2022)
- Family Planning Policy (2013)
- Boma Health Initiative (2016)

The National Health Policy includes guidance on the Basic Package of Health and Nutrition Services (BPHNS), which was created as a package to achieve universal health coverage in South Sudan [85]. While current policies indicate the government should be the primary investor in the national health budget, this has differed in practice, as the health system is almost entirely supported by various external actors and funding sources, with the government investing between 1-5% annually over the last few years [23], [91]–[93]. To address health information management, the government introduced the use of District Health Information System 2 (DHIS2) in 2011. DHIS 2 is a global data management software that has been made available free of charge to many developing countries around the world [94]. It has provided a common reporting mechanism used by both the Ministry and non-governmental organizations (NGOs) [23]. However, the reported data is often submitted on an inconsistent basis, is incomplete, or of low quality, hence, not as sufficiently used for assessment and evaluation purposes [23].

## METHODS

Researchers from CHH conducted qualitative research for this case study, which included a document review along with key informant interviews (KIIs) and group in-depth interviews (IDIs) with select stakeholders. These included government officials/MOH, United Nations agencies, institutional donors, international/national/local non-governmental organizations (I/N/LNGOs), and private sector and facility-based service providers. A total of 41 KII and IDIs were conducted in Juba capital and county and Bor, South Sudan. **Annex C** provides a list of all stakeholders interviewed. The data was synthesized and analyzed to ensure a comprehensive, nuanced understanding of the HDpN and its application to FP/RH/MNCH interventions.

## ETHICAL CONSIDERATIONS

The Johns Hopkins Bloomberg School of Public Health determined this project does not constitute human subjects research as defined by DHHS regulations 45 CFR 46.102 and, therefore, does not require institutional review board (IRB) oversight. In South Sudan, the study protocol was reviewed by the IMA World Health country office in Juba prior to data collection.

## FINDINGS

### CRITICAL OBSERVATIONS

#### *Is “Development” a Misnomer In the Absence of Peace?*

From the outset, the notion of humanitarian and development interventions did not align with the reality of programs being delivered, specifically in terms of health. The development funding in South Sudan is primarily lifesaving in nature, with the aim to keep basic health systems functioning, similar

to humanitarian programs. The development funding is for a longer time (usually 5 years) than the humanitarian funding (usually 1 year, although there is now some multi-year humanitarian funding). In essence, many of the development programs in South Sudan are addressing humanitarian issues with a longer funding cycle. Throughout this report, we will refer to development funding as “longer-term humanitarian funding.” At a foundational level, much of this stems from the absence of peace in South Sudan, with the critical assumption of SDG 16 that “there can be no sustainable development without peace and no peace without sustainable development” [95], [96]. As it pertains to health, the large reductions of funding from various donors, particularly on the development side, and the consequent closure of numerous facilities across the country between 2022 and 2023, have made basic health service provision a priority for both humanitarian assistance (HA) and development assistance (DA). This has occurred at the expense of moving toward universal health coverage, as was initially intended following a revitalized peace agreement in South Sudan [97], [98]. Consequently, development funding for health (the two largest are the Health Pooled Funds (HPF) and World Bank (WB) funds, to be discussed in more detail in the Financing section below) still primarily covers humanitarian activities. There is limited investment in health systems strengthening and health system resilience, at scale, as these have often been deemed infeasible in South Sudan in the absence of peace and competent, transparent governance [99], [100]. Given these realities and entrenched structures at the institutional level, investment at the community level may be the most plausible way to bring “peace dividends” at this point in the absence of a political solution<sup>1</sup>.

### ***The Structure and Systems of Institutions: a current barrier, but potential enabler of a meaningful nexus approach***

The structure and systems of various institutions and agencies were observed as a major barrier to effective HDN leadership, financing, and coordination, and ultimately prevented meaningful nexus approaches from being implemented within, between, and across humanitarian and development actors and their programs. This was the situation for nearly all stakeholders, but it was most visible for organizations working in both humanitarian and development sectors (i.e., dual mandate) and those working in humanitarian, development, and peace sectors (i.e., multi-mandate), where each of these mandates was covered by separate departments. This phenomenon was observed among many donors, UN agencies, and NGOs. The multi-mandate nature of these agencies translated into humanitarian, development, and where applicable, peace, or stabilization arms, which were separate and siloed. Given how large, entrenched, and bureaucratic many of these agencies are, it was cited as nearly impossible to break down these barriers. These institutional barriers are well known and openly recognized by most individuals interviewed, and yet this reality prevented intersectoral and interdisciplinary work from occurring in a meaningful and systematic way in the South Sudanese context. However, there were many individual attempts within and among organizations to try to address them through informal coordination between and amongst individuals from the different departments/units (e.g., humanitarian, development, stabilization arms), however limited. Ultimately, fundamental change to break down these institutional barriers requires strong and strategic leadership decisions that are financial, structural, and political in nature. Many agencies are also grappling with their own commitments to localization and how to move the decolonizing aid narrative from theory to practice [101], [102]. Without concrete action regarding these two critical

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<sup>1</sup> 114—Key Informant, UN Agency

agendas (institutional reform and localization) in the humanitarian, development, and peace sectors, there will be limited progress of the nexus, which entails its proper operationalization to ensure that humanitarian and development actors are working more closely together, and ultimately, more effectively. Respondents from various agencies cited collaboration and coordination on an individual, informal basis to proactively coordinate with one another without having explicit “nexus” guidance from home offices/ headquarters that mandated and described how to do it in practice, as one multi-mandate donor noted.<sup>2</sup>

## CORE PILLARS

### ***The Critical Nexus Trifecta: leadership, financing, and coordination***

Drawing from the original conceptual framework (Figure 1), the interviews probed the core pillars of leadership, finance, coordination, preparedness and planning, and information management. During the analysis of the data, the pillars of leadership, financing, and coordination emerged as prominent, standalone concepts. However, the data also demonstrated the inextricable links between these three elements. Just as siloed institutional structures were deemed to have a critical impact on nexus approaches, the three constructs of leadership, finance, and coordination also had a broad and holistic effect on the health sector and service delivery. While the pillars of preparedness, planning, and information management play a vital role in a nexus approach, these have been integrated into other sections of this report.

## LEADERSHIP

### ***Health Governance: a complicated and delicate affair***

In principle, the MOH of South Sudan leads the health sector across the country, with stakeholders such as the UN and other actors, co-leading and supporting these efforts. Donor restrictions to paying MOH staff (e.g., often referred to as “zero-cash” policies for USAID), coupled with the indirect effects of targeted sanctions, have had a critical impact on engagement with the government in South Sudan [29], [30]. Because of this, MOH officials and government employees have often been bypassed, and consequently found it challenging to provide leadership, particularly when funding has primarily been channeled to UN agencies and INGOs who manage many of the health services across the country through development or humanitarian funding schemes.<sup>3</sup> Due to these restrictions in engaging with the MOH and other government counterparts, there has been a visible impact on the sustainability of health services. This is particularly the case for MCH, SRH, and FP services, as the closure of hospitals and clinics across the country in 2022/2023 has exposed gaps in leadership and ownership by the government. Many of these facilities were to remain operational following full handover to the government, but this has not materialized despite the government’s agreement to do so during transition plans for the MOH in 2022/2023.

In addition to these factors, limited political will and unfulfilled promises by the government to significantly increase its investment in the national health budget, on average between 1-5% over the

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<sup>2</sup> I21—Key Informant, Donor Agency

<sup>3</sup> I6—Key Informant, Private Sector (International Development)



last few years, has put tremendous strain on donors to sustainably fund the health sector [91]–[93]. These figures are significantly lower than the target of the Abuja Declaration of 2001 where heads of state within the African Union made commitments to invest 15% in national health budgets [103]. The discrepancy between this target and the South Sudanese government’s investment in its own national health budget has become even more pronounced. This is even more concerning amid a global backdrop of dwindling resources and changing donor priorities, increasing humanitarian needs in fragile settings, the heavy impact of violent conflicts on civilian populations, and limited sustainable solutions in the absence of peace [104]. The culmination of these factors in an environment as complex as South Sudan has contributed to a certain degree of symbolic leadership by the government along with limited ownership and decision-making power. The institutional donors and the UN agencies have a tremendous amount of autonomy to make decisions, resulting in limited engagement between governmental and non-governmental leadership bodies, and ultimately, siloes. [158]–[160]

### ***Parallel Structures of Leadership***

The siloes among the leadership bodies in South Sudan, particularly the MOH and health development actors, have created parallel leadership structures, and the impact of this has been most visible with gaps in sustainability, handover, transition planning, and exit strategies. There has been limited accountability by the government in taking on services as major initiatives phase out, despite agreements to do so. This has been the case for the scale-down of health development funding and a “Future of Health” outlook currently being developed for 2024 onwards following the closure of different donor-funded programs [92], [105]. Multiple respondents emphasized the difficult position they were in with a government-led and government-mandated approach that did not always translate to concrete action:

*“Again, the missing part is government capacity because whatever you do, [...] the endgame is we want to exit as IP, as implementing partner, we want to exit. That’s the endgame, so the community, the government will take it out. Without active government is [impossible]”* I7—Key Informant, International NGO

Another respondent from a donor agency found it impossible to play a support role with the government not fully taking ownership of the health system:

*“But for the system to be sustainable you need to have the government stepping in that says like, it’s not so at the moment is not sustainable until you have a government that is owning the health system [...] then it can be sustainable and putting money into the system.”* I21—Key Informant, Donor Agency

## **FINANCING**

The funding landscape in South Sudan is extremely complicated with separate financing streams for both humanitarian and “development” assistance along with several rapid funding mechanisms that may be activated during emergency periods. These rapid funds entail a cross-cutting element between humanitarian and development assistance. Various health initiatives have been funded and launched prior to the Comprehensive Peace Agreement in 2005 between northern and southern

Sudan and since the country's independence in 2011 [7], [106]. Table 3 below lists some of the major funds utilized for development and humanitarian activities in South Sudan to date, including both development and humanitarian funds that have a cross-cutting emergency component. The largest health development funding is comprised of two distinct mechanisms covering different states in South Sudan, with the HPF covering eight states and the WB covering the remaining two through 2022 [107], [108]. The HPF has had three distinct phases since 2012 [107]. Maps of current HPF 3 coverage by lot are provided in Annex D to demonstrate geographic scope. As of 2023, the WB covers three states with the HPF covering the other seven due to funding cuts to the HPF, whereby the WB agreed to take over a state previously funded by the HPF. Further funding cuts are expected by the HPF. There are discrepancies between the HPF and WB health service packages, quality standards, and scale in the geographic regions covered by each mechanism. Additionally, the WB-covered states are considered significantly more challenging to work in given instability and insecurity compared with HPF states.<sup>4</sup> In terms of humanitarian health funding, this has been channeled by institutional humanitarian donors primarily to UN agencies and NGO partners. These donors include USAID's Bureau for Humanitarian Assistance (BHA), the United Kingdom's Foreign, Commonwealth & Development Office (FCDO), the European Union's Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO), Germany, and Canada, among others.

As noted in previous sections, development funding in South Sudan still primarily covers humanitarian activities. The loss of development funding over the last several years due to donor fatigue, most explicitly in 2022/2023, has had a clear impact on interruptions to health services and placed a burden on humanitarian actors to address these gaps [109]. Amid hospital and clinic closures across the country due to reduced funding, the wider MCH and SRH service landscape was impacted, leaving even less space for FP to be prioritized amongst some of the actors. There was a dramatic and sudden reduction in the number of basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC) facilities given the HPF scale-down of hospitals and primary health care centers and units (PHCCs, PHCUs) due to funding cuts and the lack of government action to take over these facilities. With such health facilities losing funding from development donors over the last few years and vital services being affected, there has been a reliance on other actors to fill these gaps, particularly humanitarian funders. This has included the OCHA-managed (pooled) South Sudan Humanitarian Fund (SSHF), reserved for covering acute and protracted humanitarian activities that have been planned as part of the HRP or priority activities based on unforeseen needs [110]. Though the SSHF's short-term funding normally covers activities anywhere from 3 months to 2 years, the SSHF has been repeatedly utilized as a resource to address life-saving needs that resulted from the downsizing of development funds. In turn, sustainability of funding was raised as a key issue by multiple respondents. Efforts to coordinate sustainability at the highest levels among these actors were necessary given the need for efficiency with limited, diminishing resources. Consequently, the need for development and humanitarian actors to work more closely together is not just an HDN issue, but essential to ensure humanitarian assistance is used appropriately and effectively.

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<sup>4</sup> 119—Key Informant, Donor Agency

**Table 3. Major Development, Humanitarian, and Cross-Cutting Emergency Funds in South Sudan**

<b>Name of Fund</b>	<b>Type</b>	<b>Time Frame</b>
<b>Sudan Health Transformation Project I</b> <i>Donor: USAID</i>	Development	2004-2009
<b>Multi-Donor Trust Fund-Southern Sudan</b> <i>Donor: World Bank</i>	Development	2005-2012
<b>Basic Services Fund</b> <i>Donor: UK DFID, EU, Netherlands, Norway, Sweden</i>	Development	2005-2012
<b>Sudan Health Transformation Project II</b> <i>Donor: USAID, UK DFID, EU, Netherlands, Norway, Sweden</i>	Development	2009-2012
<b>Health Pooled Fund Phase 1</b> <i>Donor: UK FCDO, Australia, Canada, European Union, SIDA</i>	Development	2012-2016
<b>Integrated Service Delivery Project</b> <i>Donor: USAID</i>	Development	2012-2017
<b>Health Rapid Results Project</b> <i>Donor: World Bank</i>	Development	2013-2019
<b>Health Pooled Fund Phase 2</b> <i>Donor: UK FCDO, USAID, Canada, European Union, SIDA</i>	Development	2016-2018
<b>Health Pooled Fund Phase 3</b> <i>Donor: FCDO, Canada, SIDA, USAID</i>	Development	2018-2023
<b>COVID-19 Emergency Response and Health Systems Preparedness Project</b> <i>Donor: World Bank</i>	Hybrid	2021-2025
<b>Contingent Emergency Response Component</b> <i>Donor: Embedded within World Bank Funding</i>	Development, cross-cutting emergency	N/A
<b>Crisis Response Window</b> <i>Donor: International Development Association</i>	Development, cross-cutting emergency	N/A
<b>Emergency Preparedness &amp; Response Fund</b> <i>Donor: Embedded within HPF</i>	Development, cross-cutting emergency	N/A
<b>Multi-year Emergency Awards</b> <i>Donor: USAID</i>	Humanitarian	N/A
<b>Central Emergency Response Fund</b> <i>Donor: Multi-donor pooled fund, managed by OCHA</i>	Humanitarian	N/A
<b>South Sudan Humanitarian Fund, Standard Allocation</b> <i>Donor: Multi-donor pooled fund, managed by OCHA</i>	Humanitarian	N/A
<b>South Sudan Humanitarian Fund, Reserve Allocation</b> <i>Donor: Multi-donor pooled fund, managed by OCHA</i>	Humanitarian, cross-cutting emergency	N/A
<b>Emergency Rapid Response Mechanism</b> <i>Donor: ECHO</i>	Humanitarian, cross-cutting emergency	N/A
<b>Rapid Response Fund</b> <i>Donor: USAID</i>	Humanitarian, cross-cutting emergency	2015-2022

## COORDINATION

### **Coordination Bodies in South Sudan: “fragmentation is the name of the game”<sup>5</sup>**

Coordination mechanisms in South Sudan are very complex with multiple coordination fora existing within and across humanitarian, development, and peace actors. Based on numerous respondents’ perspectives, coordination was fragmented, siloed and duplicative, and sometimes more symbolic than substantive. Table 4 lists some of the major platforms currently in place.

**Table 4. Coordination Fora in South Sudan**

<b>Name of Coordination Body</b>	<b>Type</b>
Strategic Advisory Group	Development
Donor Working Group	Development
Donor Working Group	Humanitarian
Resilience Advisory Group	Humanitarian-Development
Reproductive Health Coordination Forum	Development
National Steering Committee	Development
Heads of Coordination, Heads of Mission (HoCs/HoMs)	Humanitarian
National Health Cluster	Humanitarian
National Health Cluster, RH Working Group	Humanitarian
Sub-national Health Cluster(s)	Humanitarian
Reproductive Health Emergency	Humanitarian
Community Health Committees	N/A

Standard humanitarian coordination platforms exist for health implementation, including the Health Clusters at the national level led by the MOH and co-led by the WHO. At the sub-national level, the health clusters are led by the State MOH and co-led by the WHO and an NGO (usually an INGO). OCHA implements its expected role of coordinating the overall cluster system within the country. Coordination in this traditional sense primarily brings together humanitarian actors, but it also includes some dual- and multi-mandate actors, such as USAID and the EU. While many actors defined themselves as dual or multi-mandate actors, there was less clarity on how development and humanitarian assistance were integrated in practice, with one respondent emphasizing that separate meetings (and fora) for humanitarian and development occurred, but were often attended by the same individuals and organizations:

*“Sometimes we do have like a joint meeting because it is the same partners. Some of them [have] two arms, development and humanitarian [...] it is the same key stakeholders that meet in different [platforms where the] mandate is different. This one is in humanitarian and this one is in development.”*<sup>15</sup>—Key Informant, National NGO

The formalized coordination mechanisms for development health actors were less clear, with some meetings occurring at the capital and state levels for both the WB and HPF partners. Regular meetings

<sup>5</sup> 119—Key Informant, Donor Agency

among the development actors in the three northern states (i.e., World Bank-UNICEF group) with implementing partners MSF and the ICRC were occurring at the state levels to conduct prioritization exercises. Several development actors noted that coordination with humanitarian actors was not donor-mandated, but rather sometimes occurred “just at the lower level, at the community level.”<sup>6</sup> Another respondent emphasized that although not required, coordination was encouraged, which was often difficult to do in a meaningful way given the competitive environment for development actors:

*“IPs [implementing partners] at the end of the day, they compete against each other for contracts, for the money. So, the history is of IPs is working in siloes. So, when PfRR [Partnership for Resilience and Recovery] came about, it was meant to be a platform in which [...] everybody's working together to increase resilience and reduce vulnerability in the households, but it's hard to teach an old dog new tricks. People are used to competing against each other.”*  
I6—Key Informant, Private Sector (International Development)

In terms of coordination between and among humanitarian and development donors, there is a less clear picture of how consistent these efforts are in South Sudan. Based on interviews conducted, there are regular coordination meetings taking place between humanitarian donors given the explicit coordination mandate in the humanitarian space.<sup>7,8,9</sup> One donor speculated that there may have been some duplication or redundancy in coverage with so many actors operating in one region.<sup>10</sup> In the case of development donors, such coordination efforts were less apparent, and for that matter, less intentional. Despite development donors meeting periodically amongst each other, there were fewer incentives to coordinate such efforts given the geographic division of coverage by state (i.e., HPF 7 states, WB 3 states). The most recent funding cuts demonstrated more explicit efforts to coordination between both donors given the HPF’s funding cuts reducing state coverage and the WB’s agreement to inherit one of the states. Coordination between humanitarian and development donors was less routine, with more recent efforts by multi-mandate donors, such as the German Mission, working to bring together both humanitarian and development donors.<sup>11</sup> The integrated office under the UN deputy secretary-general/resident coordinator/humanitarian coordinator (DSG/RC/HC) in South Sudan reflects that same effort to conceptualize a more coherent approach to bringing together humanitarian and development actors, specifically donors and implementing agencies. These initiatives are still in the nascent phase, as there is still a divide within and between humanitarian and development coordination fora for health interventions and funding.

### **Field Level Coordination for Services and Service Providers**

Coordination on the ground for community-level interventions demonstrated a great deal of overlap among service providers. It was unclear how many community workers were wearing multiple hats,

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<sup>6</sup> I13—Key Informant, Donor Agency

<sup>7</sup> I12—Key Informant, UN Agency

<sup>8</sup> I21—Key Informant, Donor Agency

<sup>9</sup> I37—Key Informant, International NGO

<sup>10</sup> I21—Key Informant, Donor Agency

<sup>11</sup> I12—Key Informant, UN Agency

and concerns around sustainability emerged when discussing various community-level cadre, including but not limited to family planning, HIV/TB teams, routine immunizers, community nutrition volunteers, community health workers, hygiene health promoters, BHWs, and COVID-19 vaccinators. This overlap of community workers is linked to several issues, particularly a lack of coordination amongst various partners and funding from donors that focus on specific programs.

This overlap and duplication in many of the community-level cadre for various health services was also noted amongst numerous actors and across different areas of both vertical and horizontal service delivery [111]–[113]. At the community level, health committees were in place and tried to support PHCCs and PHCUs. These grass-roots efforts are an attempt to better coordinate and relay communities’ needs.<sup>12</sup> However, there was also a lack of clarity of if and when stock-taking exercises occurred. It was unclear if rationalization exercises for different community-level interventions were conducted to determine top priorities, as it appeared that different agencies wanted to maintain their own footprint in various geographic locations. This was also the case for more “niche” programming where donors were not always aware of other services that may be deemed less of a priority, such as FP, as will be discussed in a later section. The distribution of hospitals and PHCCs in each geographic location also illustrated how upstream decisions in the capital may affect the field, and often lead to duplication of efforts by stakeholders involved. One donor voiced concern over the number of actors operating under one roof, which includes a chain of donors, intermediary agencies, implementing partners, and sub-implementing partners:<sup>13</sup>

*“And so, in [Pibor] hospital, for example [one INGO] was doing the stabilization center, [one NNGO] was doing the health service delivery, and then there was [another INGO] and another partner who were doing MAM [moderate acute malnutrition]. So, we had six partners working in one particular facility.”*

### **Information Management and Sharing: gaps, resistance, and how information drives the prioritization of needs**

Information sharing was a critical factor raised in driving prioritization of needs between humanitarian and development actors, as was the case for states covered by either the HPF or WB. It was also raised as a barrier in terms of supply chain management and reliance on a “push system” in the country, rather than a consumption-driven one, particularly for FP/RH/MNCH drugs and supplies (see Service Provision section below). Integrated call centers are one such interim effort that has been put in place to retrieve real-time data and help make better-informed decisions that align with procurement and consumption/utilization rates. These pilots should be expanded to ensure a real-time data collection and response system for supply chain management. Many of the barriers to achieving this stem from the lack of adequate infrastructure, the absence of accountability measures, and the inability to make informed decisions based on gaps in data, along with challenges in accessing routine quality data, as one respondent noted:

*“Infrastructure is not here. Accountability is not here. I think with that, sometimes, you have data, but data is only as good as analyzing it, turning it into information that can inform*

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<sup>12</sup> I40—Key Informant, Community Health Agency

<sup>13</sup> I21—Key Informant, Donor Agency

*decisions [...] For us, it's not one-dimensional [...] our focus being that coordination piece, and it takes time to establish that, how are we sitting there and supporting the CMS [central medical store] but really working with so many different entities to ensure that the information is being passed through, understood, and then adjustments, changes, actions can happen?"* 111—Key Informant, Private Sector (International Development)

### **Mapping: the need for a comprehensive picture of health implementers, donors, & stakeholders**

Mapping is closely linked with information sharing and coordination. Numerous platforms exist that provide maps, including Clusters (e.g., Health, Nutrition), the HPF, and UN agencies [107], [114]–[118]. **Annex E** provides examples of these operational maps in South Sudan [115], [116]. Despite these platforms, there is currently no comprehensive map that reflects all humanitarian and development funding and activities across the country along with all stakeholders involved from implementing organizations, donors, and UN agencies. Consequently, it is extremely difficult to comprehensively understand the potential complementarity and overlap of humanitarian and development funding, actors, and interventions. A positive example is the South Sudan Health Service Functionality Dashboard which focuses on providing quarterly data on RMCH service availability from DHIS2<sup>14</sup> [118]. During interviews, there were discrepancies from respondents' perspectives on how often this was updated<sup>15,16</sup> [119]. The dashboard does indeed outline where facilities are located by state and administrative area, and which of these meet the threshold under the BPHNS and other health-related indicators. However, there is no single platform that includes all humanitarian and development actors and offers a cohesive picture of both the funding and implementation landscape in South Sudan. Without this clear picture, it is difficult to address the efficiency of actors and interventions, as well as improved coherence with transition/phasing out plans, particularly as funding continues to reduce in South Sudan.

## **HEALTH SERVICE PROVISION & PROVIDERS**

### *Applications of FP/RH/MNCH*

#### **Long-term Investment in FP/RH Interventions: A Key Driver for Improving Maternal Health Outcomes**

Investment in FP has been linked to the Sustainable Development Goals [120], [121]. The linkage between FP and maternal health outcomes has shown convincingly that FP is a lifesaving intervention, particularly for communities affected by conflict, natural disasters, and displacement who may have limited access to quality maternity services [159]. This is particularly the case in South Sudan given it has the highest ratio of maternal mortality (1,223/100,000 live births) relative to the global average (223/100,000 live births) with a contraceptive prevalence rate of approximately 4% relative to the global average of 63%.

In September 2021, South Sudan's MOH and the UN Population Fund (UNFPA) developed an Investment Case for Ending Unmet Need for Family Planning, Preventable Maternal Deaths and

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<sup>14</sup> |21—Key Informant, Donor Agency

<sup>15</sup> |19—Key Informant, Donor Agency

<sup>16</sup> |21—Key Informant, Donor Agency

Gender-Based Violence to address the staggering rates of maternal mortality and morbidity [122]. In December 2022, the government launched its FP2030 commitments to increase the contraceptive prevalence rate from the current estimate between 2-6% according to UNFPA and WB data up to 20% by 2030 [61], [123], [124]. The investment case and commitments provide a comprehensive picture of baseline coverage rates for maternal health interventions and modern contraceptive use as of 2020 along with three different target rates by 2030: “moderate,” “achievable”, and “ambitious.” The MOH outlines what will be needed to meet these targets in terms of drugs and supplies, finances, and the required human resources (Table 5) [122].

**Table 5. Maternal Lives Saved by Scaling Up Coverage of Maternal Health Interventions**

MATERNAL HEALTH INTERVENTION	2030 MATERNAL LIVES SAVED		
	MODEST COVERAGE SCALE-UP (30%)	ACHIEVABLE COVERAGE SCALE-UP (50%)	AMBITIOUS COVERAGE SCALE-UP (100%)
<b>Periconceptual</b>			
Contraceptive use	292	371	366
Post abortion case management	15	37	83
Ectopic pregnancy case management	2	9	22
<b>Pregnancy</b>			
Micronutrient supplementation	111	372	921
TT - Tetanus toxoid vaccination	5	5	15
Intermittent preventive treatment of malaria	73	66	230
Syphilis detection and treatment	0	0	0
Calcium supplementation	149	224	379
Balanced energy supplementation	0	0	0
Hypertensive disorder case management	328	523	931
Diabetes case management	0	0	0
Malaria case management	30	55	121
Fetal growth restriction detection and management	0	0	0
<b>Childbirth</b>			
Clean birth environment	97	161	259
Manual removal of placenta	220	315	413
MgSO4 for eclampsia	114	321	551
Antibiotics for preterm or prolonged PROM	45	73	117
Parenteral administration of antibiotics	137	222	354
Assisted vaginal delivery	298	471	860
Parenteral administration of uterotonics	457	750	1,076
Removal of retained products of conception	225	316	416
Induction of labour for pregnancies lasting 41+w	0	0	0
Antenatal corticosteroids for preterm labour	0	0	0
Cesarean delivery	313	437	588
Blood transfusion	531	730	974
<b>Preventive</b>			
ITN/IRS - Households protected from malaria	0	0	0
<b>Curative</b>			
Maternal sepsis case management	46	112	126
<b>Total maternal lives saved</b>	<b>3,488</b>	<b>5,570</b>	<b>8,802</b>

Recognition of the explicit linkage between FP and maternal health is essential for ensuring awareness, acceptance, and uptake in South Sudan. One of the key issues raised by numerous stakeholders interviewed in Juba and Bor was the degree of acceptance of FP interventions by communities. Targeted efforts for individuals and couples have included awareness campaigns rolled



out through various platforms to address barriers to uptake, using health as an entry point, as one service provider noted: *“Those cultural norms are there, but how we can overcome them, it takes a lot of sensitization [...] Sometimes I used to go to radio talk shows, and they'd throw me a lot of questions, but I have to defend that it is your health, it is the health of your family”* [125]. Misconceptions and pervasive cultural norms posed significant barriers to the utilization of FP services, and stakeholders provided examples of how intertwined these factors often are, such as the practice by some ethnic groups of abstaining from sexual intercourse during breastfeeding for two years due to the belief that this may be harmful to the infant or require consent from a woman’s husband before she can receive counseling from an FP provider<sup>17</sup> [126]. Service providers interviewed in Bor emphasized the fine balance needed in promoting SRH without undermining cultural beliefs and practices, given FP interventions are more effective through approaches that address social and behavioral change and challenge deep-rooted sociocultural and gender norms [127]–[129].

One field coordinator reflected on the gradual expansion of health programs in eight counties to include FP and to create demand for such services despite apprehension due to cultural beliefs:

*“Family planning and reproductive health used to be something that factor in the health, but nobody really was supporting it for many years. I think it's one of the sectors that was in the health that was being ignored for many, many, many, many years [...] When you look culturally in Dinka culture, of course, family planning is not something acceptable in our culture completely [...] when we started in Pariak [PHCC], there was not even anybody knowing about family planning. It was completely a new thing that was introduced, and I think because of [...] demand creation, people begin realizing that there is importance of family planning.”* I41—Key Informant, International NGO

He added that long-term investment was not limited to promoting contraceptive use, but also relied on enhanced engagement with men and linking utilization with economic recovery and livelihood:

*“Even men-to-men engagements become really very important on this project because men become realizing, “Yes, I think I have to go to the [PHCC] to learn about family planning.” The great impact that is not only looking at the issue of preventing you not to give birth but also, it's attached to other benefits. Most of the benefits are aligned with the solution, with the economic solution we are in today because people want to work. People want to give also their wife time for breastfeeding and [...] a chance also to work and contribute to the food in the house. Also, people understand that there is a benefit on the health because sometimes giving birth, you need also to have a time for your wife to have a strong body so that you will be able now to manage to bring these children up.”* I41—Key Informant, International NGO

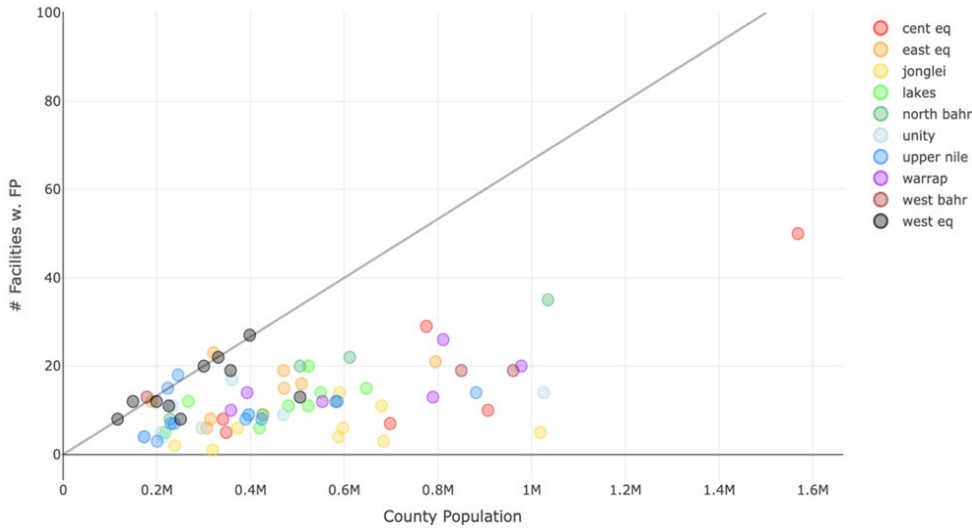
With the shifting—and shrinking—funding landscape in South Sudan, it was apparent that FP was not always prioritized given other, as some suggested, more pressing, life-saving needs. The WHO’s Health Service Functionality Dashboard provides information on all facilities that offer FP, BEmONC, CEmONC, ANC, and PNC services. Based on the BPHNS criteria recommended (listed in the Health System Overview section) and the most recent data available as of May 2022, nearly all states in South Sudan fall below the suggested threshold for availability of FP, ANC, PNC, BEmONC, and CEmONC,

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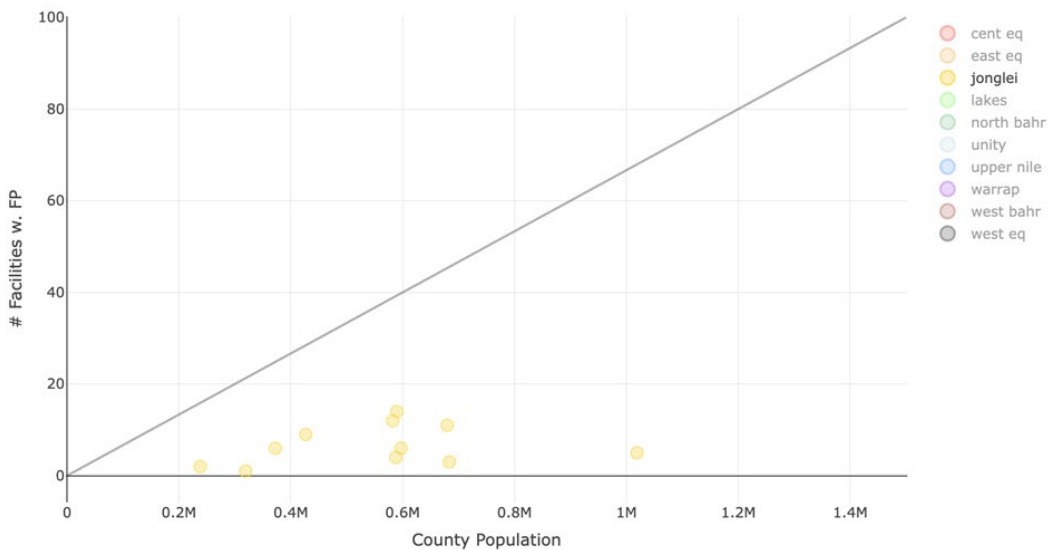
<sup>17</sup> I40—Key Informant, Community Health Committee

apart from a few counties [88], [117]. These interventions were not at scale across the country and did not meet the threshold for adequate coverage for most counties and states, according to the BPHNS. Service coverage for FP is depicted across all states and in Jonglei state (including Bor South) in terms of method provision and counseling in **Figures 4** and **5** below, respectively [117]. A summary of coverage figures for ANC, PNC, BEmONC, and CEmONC services are available across all states and Jonglei state in **Annex F** [117].

**Figure 4. FP Service Coverage Across All States**



**Figure 5. FP Service Coverage Across Jonglei State**



Given competing priorities among other life-saving health services (and those beyond the health sector) that are visible across the country, it is apparent that FP was not always prioritized by all actors. Amid hospital and clinic closures across the country due to reduced funding, the wider SRH service landscape was impacted, leaving even less space for FP to be prioritized amongst some of the

actors. Furthermore, sociocultural and acceptance barriers were repeatedly mentioned as other reasons for not prioritizing FP.

There appeared to be limited buy-in regarding FP across many of the humanitarian actors, in particular, as FP was still deemed more of a development activity, despite its inclusion in the Minimum Initial Service Package (MISP) for SRH as a lifesaving intervention in crises [130]. This limited buy-in is not unique to South Sudan, as has been observed in fragile settings where there has been the need to balance numerous life-saving priorities [121], [131]. These attitudes combined with the longer time needed to affect people's behavior and acceptance towards FP make it a particularly challenging intervention in the nexus for South Sudan, as it often “*slipped through the cracks*,” as one RH provider noted, particularly with competing priorities.

*“When you say primary healthcare, it includes family planning, but in reality, sometimes, because of funding also, they act as they might find difficulties to hire a staff who is responsible for family planning. Because family planning is not like any other services. It needs a lot of counseling. You need to do counseling for even more than 30 minutes, and then you provide. But sometimes, they can hire, like I said, one midwife. That midwife is responsible for antenatal care, responsible for deliveries and even postnatal care, and at the same time is assigned to family planning. So, you would find they do not have a lot of time to provide family planning [...] They [other RH services] take priority and those ones [family planning], they fall under the cracks, and then people now will be wondering where to go especially where to get their long-acting, for example, like implants and all these.”* I5—Key Informant, National NGO

Despite clear evidence demonstrating that FP is lifesaving and has been shown to reduce maternal mortality, these interventions were only a small component of the wider SRH/MCH landscape in South Sudan [132], [133]. Furthermore, despite strategies and plans to deliberately expand FP to communities by MIHR and other actors, most of these services, particularly long-acting methods, remain facility-based. However, approximately 90% of the population in South Sudan resides in rural areas and 56% of people live at least 5 kilometers (~3.12 miles) from the nearest health facility with limited financial means and no form of transportation besides walking [134]. Given this reality, the BHI was developed to address community needs at the Boma level. However, there is a severe shortage of BHWs with an estimated coverage of only 30% in 8 states (HPF states) as of 2022 [134]. With this small ratio of coverage, there is an even smaller percentage of these workers offering FP services within the package of services, primarily addressing safe motherhood and child health. Although there is limited data on current FP funding gaps, a recent costing analysis in 2019 by Gilmartin et al. has estimated the gap at \$15.1 million in 2018 and projected a gap in 2028 at \$19 million, \$23.7 million, and \$30.7 million under “low,” “medium,” and “high” service coverage scenarios, respectively [135]. Clearly, there will be a serious funding gap that will impact the ability to provide the full package of health services to communities under the BHI.

MIHR has incorporated FP interventions within the services offered by BHWs. **Table 6** provides an overview of the various FP activities delivered. In Jonglei state, these were primarily delivered at the facility level by FP providers [136]. **Figure 6** provides a breakdown of the clients who were provided FP methods over time, by total, short, and long-acting methods for program years 1 and 2 [137]. Although there was buy-in from multiple actors on the importance of FP, particularly among development

actors, these interventions were often the first to be eliminated relative to other prioritized services in the face of funding cuts.<sup>18</sup> While the data provided by MIHR shows increased delivery and uptake of FP, the overall figures at the country level indicate uptake is still low in South Sudan. Incorporating FP within the mandate of BHWs has been one way to address this given the MOH has been supportive of this effort, but there are still shortcomings if not all organizations are consistently offering FP services within the BHI package, as MIHR has done. This may potentially create a different standard for what communities receive such an integrated package of services. Although not generalizable, some of the BHWs interviewed in Bor only provided basic information and services for family planning, namely on STI prevention and the distribution of condoms.<sup>19</sup> However, one development donor noted the integration of FP services by only some providers, like MIHR, creates a different standard for communities served through the MIHR project, inconsistency in service packages, and even duplication in some facilities where other programs were already in place.<sup>20</sup> Other challenges include growing these programs to scale to ensure coverage across all states alongside other critical MCH/SRH interventions, as the Health Dashboard demonstrates<sup>21</sup> [117].

One respondent reiterated the difficulty in prioritizing needs and interventions in the health sector, and those outside of the health sector as well, emphasizing this was often the reason why FP is often overlooked:

*“[There is] 1,115 per 100,000 live births that's, that's highest ever. Okay, so again, there are several factors that clearly contributes to the list is huge, okay. But certainly, one of them is certainly a weakened system, infrastructure, limited resources, you know, nurses, doctors are not paid in the I mean, we just concluded the first obstetrician and gynecologist conference, like three weeks ago here, which was a really high level officiated by the Vice President. So, I mean, many, many issues just came, you know, postpartum hemorrhage, certainly one of the key cause, which we are aware [...] But again, also one of the issues the low pay, even for staff, you know, many pregnancies, low family planning, again, nutrition is an issue here, you may be aware that, you know, more than half of population here, you know, has the acute food insecurity, to be specific 6.6 million people.”* I10—Key Informant, UN Agency

**Table 6. Summary of MIHR FP/RH Service Delivery for Program Years 1 and 2 (2020-2022)**

<b>Indicator</b>	<b>PY1 Oct. 2020 – Sept. 2021</b>	<b>PY2 Oct. 2021 – Sept. 2022</b>	<b>PY3 Oct. 2022 – Sept. 2023</b>	<b>Total</b>
Clients attended health education sessions	54,513	142,594	263,428	<b>460,535</b>
Clients Counseled on FP	18,957	45,002	56,250	<b>120,209</b>
Clients provided FP methods (new and repeat)	12,484	33,078	58,947	<b>104,509</b>

<sup>18</sup> I41—Key Informant, International NGO

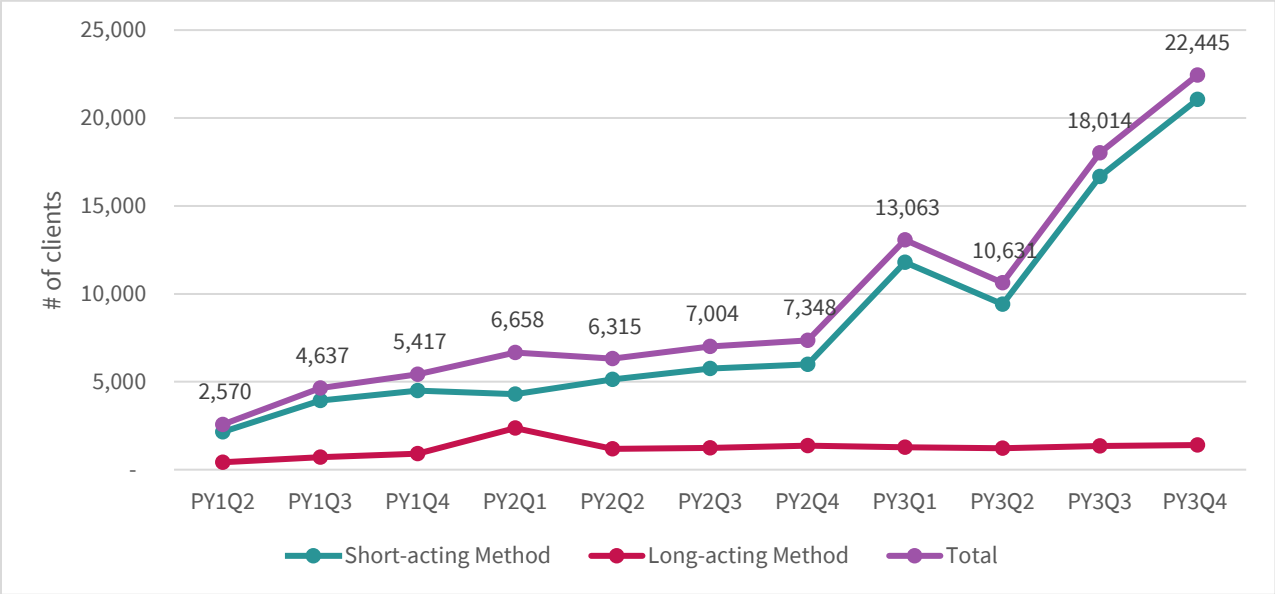
<sup>19</sup> I38—Key Informant, International NGO

<sup>20</sup> I21—Key Informant, Donor Agency

<sup>21</sup> I21—Key Informant, Donor Agency

Indicator	PY1 Oct. 2020 – Sept. 2021	PY2 Oct. 2021 – Sept. 2022	PY3 Oct. 2022 – Sept. 2023	Total
Couple Years of Protection (CYP)	9,037	19,822	25,121	<b>53,980</b>

**Figure 6. Clients Provided FP Methods Over Time, Program Years 1-3 (2020-2023)**



**Relapses in Fragility and Service Interruption: the need to address continuity of care during constant crises**

Service interruption due to numerous shocks and stresses was a critical challenge for MCH and RH service providers, particularly recurrent flooding in Jonglei State and the subsequent displacement of the population. During seasonal flooding, the number of functional health facilities drastically reduces, and affected communities are unable to access health facilities, thus impacting the continuity of care. As mentioned above, the Health Dashboard demonstrates that facility-based services already fall well below the required threshold to meet population demands, so shortages become even more pronounced during these emergency periods<sup>22</sup> [117].

In response to such interruptions, respondents outlined different approaches that were adopted to ensure service continuity. In advance of flooding periods, providers at the community level, such as BHWs, were often equipped with a buffer stock of FP supplies as a measure of preparedness to ensure access to commodities for women.<sup>23</sup> They also noted that community members themselves, including community health committees, anticipated when the facility may be stocked up again. When stocks of medicines and materials were out during these periods, communities were aware and did not come to

<sup>22</sup> I3—Key Informant, International NGO

<sup>23</sup> I3—Key Informant, International NGO

the healthcare facilities as often.<sup>24</sup> Service providers at facilities also addressed the rational use of drugs, such as the example at Bor State Hospital, giving guidance on the rational use of antibiotics. This effort is part of the WHO’s global guidance from its antimicrobial stewardship program which addresses the growing rates of antimicrobial resistance where “very few new antibiotics are being developed, existing antibiotics are becoming a limited resource” [138]. This is particularly the case in low- and middle-income countries and there is a tremendous push to prescribe antibiotics only as a “last resort” and only for patients who are truly in need of these medicines given the adverse, long-term consequences. **Figure 7** demonstrates such guidance at a grass-roots level, along with other measures taken to address the push system and inappropriate use of medicines and expired drugs. Another service provider emphasized the need to be resourceful in how to reach communities dispersed by flooding, such as using speed boats and canoes.<sup>25</sup> One provider in Bor Country recounted delivering SRH services alongside rapid response teams activated during floods:

*“Family planning for us, if we have excess of movement, we can take the commodities near to the people, because we might be missing the client which usually came to the hospital, so we have to take the services where they can access. When flooding came, it was crossing this road like this. There were people who were moving with boat, so what we did, health, etc. it was a rapid response management [...] I was one of the team leaders, I used to go to the place near the airport [...] we take the drugs [...] we were also involved in family planning, and then safe delivery kits, we used to take them there.”* I33—Service Provider at Health Facility, International NGO

**Figure 7. Guidance to Address Rational Use of Medicines, Bor State Hospital**



Photo Credit: Paul Spiegel, South Sudan (December 2022)

<sup>24</sup> I40—Key Informant, Community Health Committee

<sup>25</sup> I2—Key Informant, International NGO

Deliveries for pregnant women, especially those with complications proved even more difficult in the absence of qualified midwives, supplies, and safe delivery sites:

*“What was the real challenge was because of night. At night, those who came for deliveries, they were not able to cross [...] they need to deliver there, and we were not having a midwife who can [inaudible] it was tedious. What we did, we built a small tent, and we put [...] the materials for deliveries. If there is a delivery, they used to bring the other one to the outside, and then it would close if there were complications. If it is the normal delivery, they used to use that.”* 133—Service Provider at Health Facility, International NGO

Integration of services during these emergency periods was another critical aspect emphasized to ensure complex needs were met given the long-term consequences in the absence of interventions that address FP, sexual violence, and HIV (essentially the MISIP):

*“This is what we normally do during crisis, we involve family planning [...] whatever is happening, there might be rape cases, there is these unwanted pregnancies, and then a lot of those who are even taking the ARVs [Antiretrovirals for HIV] like pregnant mothers who are always receiving [P]MTCT [Prevention of Mother-to-Child-Transmission] services, they cut off their services. Those people who need to be given the services by the NGOs concerned.”* 133—Service Provider at Health Facility, INGO

In contrast, one NGO providing targeted HIV services offered a different perspective on the barriers to operation during such periods of instability, stemming from its mandate to operate within existing public, government structures, but also noted the organization’s capacity limits to shift to emergency response during these periods of flux, resulting in service interruption.

*“If the facility is affected even for us as [NGO], we ride on the government structures. So, if the facility is affected, [our NGO] doesn’t have that capacity of maybe putting up an emergency, a facility to carry out activities. Because, for us, we ride on the existing public health facilities, which are established by the government [...] When that service is interrupted, [our NGO] waits until when there is stability, yes.”* 117—Key Informant, International NGO

Other ways providers addressed service interruption in terms of FP methods included the provision of long-acting, reversible contraceptives (LARCs), such as injections (e.g., Sayana Press, Depo-Provera) and hormonal implants (e.g., Jadelle, Implanon), during flood season for women who wanted longer-acting options. These were also noted as an ideal option for other displacement scenarios that frequently prevented women from accessing health sites, including during harvesting seasons and bouts of violence and insecurity.<sup>26</sup> Despite the availability of LARCs as an option and a push for methods that included self-administration given the growing body of evidence around investment in SRH self-care interventions in fragile settings, utilization rates in Bor South indicate a low uptake of such methods. Reasons for why this is the case may stem from disrupted access to healthcare, cultural barriers mentioned above, and other factors that warrant further examination [139], [140]. One of these factors that warrants examination is a workforce shortage of higher-level clinical cadre who can provide a wider range of contraceptive services (e.g., intrauterine device insertion and

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<sup>26</sup> 13—Key Informant, International NGO

removal), as is the case in many other contexts [141], [142]. The next section will delve into human resource implications and workforce development as it pertains to FP and to the wider health landscape in South Sudan.

## **HUMAN RESOURCES & WORKFORCE DEVELOPMENT**

### ***A Viable, Local Health Workforce: extremely challenging and complex environment***

A capable South Sudanese health workforce is critical for ensuring the health system is functional. Human resources, particularly national and local cadre, are the backbone of any health system [143]. In fragile settings, investment in human resources is even more imperative, as this domestic health workforce must possess strong capacities to respond to shocks and stresses while also being an integral part of longer-term development transitions and scenarios. This is explicitly linked to the localization agenda and the notions of sustainability, resilience, and durable solutions, as will be discussed later in this report. With a visible reliance on international stakeholders in South Sudan in terms of both humanitarian and development assistance (i.e., the nexus), there must be a greater effort invested in local workforce development, including education, recruitment, retention, and training.

The current health workforce in South Sudan is extremely limited, with only one physician for every 65,574 people in the country [144]. The availability of nurses and midwives is 0.3 per 100,000 people as of the most recent 2018 data made available by the WB [145]. These figures are alarming, as the WHO recommends a minimum ratio of 23 physicians, nurses, and midwives per 10,000 population in order to achieve and maintain adequate coverage rates for primary healthcare interventions [146]. The complex operational environment and heightened insecurity in different parts of the country have made it extremely challenging for medical professionals to safely deliver quality services, as emphasized by numerous agencies since 2013, including the ICRC, MSF, and USAID [147]–[149]. Between January 2016 and March 2023, 148 incidents of violence toward HCWs and health facilities in South Sudan have been documented by the Safeguarding Health in Conflict Coalition [33], [34]. This violence includes damage to 10 health facilities, the killing of 57 health care workers, the abduction of 34 persons, and injury of 52 others [33]. Specifically as it pertains to FP providers, some of these cadre in different rural Payams of South Sudan have experienced physical assault, verbal abuse, threats, and even in some instances been fined or imprisoned by traditional courts when spousal consent was not obtained prior to seeking FP services [127].

Efforts to recruit, train, and retain human resources have been extremely difficult given significant funding cuts from health sector donors and less than 2% investment in the health budget by the government in 2022 [91], [105]. The combined impact of funding cuts and a meager national health budget has also impacted Juba Teaching Hospital, a vital facility in terms of both service delivery and medical education. The hospital has been funded since 2005 with the first Multi-Donor Trust Fund established in South Sudan prior to and following independence [150]. The agreed-upon handover from health sector donors, such as the HPF to the MOH, has demonstrated significant gaps in transition with the loss of 220 health facilities from a total of 797 between 2022 and 2023, including 10 hospitals in eight states, including the Juba Teaching Hospital [98], [151].



The impact of zero-cash policies on MOH staff has inadvertently created a parallel hiring and compensation structure for HCWs in the public sector, where many implementing agencies who are providing humanitarian and/or development assistance (e.g., I/NGOs) have provided incentives to the public health system but have also hired workers outside of the system with higher salaries [30]<sup>27</sup>. Much of this is due to institutional donor red lines and zero-cash policies, which have prevented staff hired by the MOH from receiving salaries, thus only permitting international actors to pay incentives or “top-ups,” which often exceed the salary amount of MOH staff, as multiple respondents emphasized.<sup>28,29,30,31,32</sup> To add to this, delayed payments of salaries by the government—often up to six months according to some respondents—has contributed to a greater disparity between government staff (namely MOH) and those hired by local and international NGOs.<sup>33,34,35</sup> Although the MOH developed a salary scale for government HCWs at PHCs and hospitals in 2019 and disseminated this circular to all health partners, enforcement of these pay scales has been limited given the issue of top-ups, ultimately perpetuating salary inequities and inequalities, and contributing to a major loss of motivation according to many respondents interviewed [152]<sup>36,37</sup>. This discrepancy in salaries has created a competitive environment where many local service providers prefer the consistency offered through international actors and have opted to work for such agencies in their well-founded desire for financial stability.<sup>38,39</sup> Ultimately, in the long-term, inconsistencies in service packages, hiring practices, and compensation structures have disturbed the health system and hindered sustainable efforts for a health system that takes into consideration the equity, quality, and harmonization of services.

Educational programs including medicine, nursing, and midwifery will inevitably be impacted by the current donor funding cuts, resulting in more limited employment opportunities in the public health sector and an absence of teachers in these schools.<sup>40</sup> Investment in the national education budget was 17.2% of total government spending for 2022/23, which certainly shows a demonstrated increase from prior years of 11.2% (2020/21) and 16.1% (2021/22), however, still falls below the global benchmark of 20% and is lowest relative to other countries in East Africa [153], [154]. How much of the national budget is earmarked for higher education is unclear, though policies developed by the Ministry of Higher Education, Science and Technology (MoHEST) indicate efforts to include cost-

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<sup>27</sup> I40—Key Informant, Community Health Committee

<sup>28</sup> I3—Key Informant, International NGO

<sup>29</sup> I21—Key Informant, Donor Agency

<sup>30</sup> I31—Key Informant, National NGO

<sup>31</sup> I34—Key Informant, International NGO

<sup>32</sup> I37—Key Informant, International NGO

<sup>33</sup> I12—Key Informant, UN Agency

<sup>34</sup> I32—Key Informant, International NGO

<sup>35</sup> I36—Key Informant, Government Ministry

<sup>36</sup> I21—Key Informant, Donor Agency

<sup>37</sup> I26—Key Informant, Service Provider at Health Facility

<sup>38</sup> I17—Key Informant, International NGO

<sup>39</sup> I37—Key Informant, International NGO

<sup>40</sup> I10—Key informant, UN Agency

sharing and a loan system for universities along with formalizing a National Higher Education Policy Framework for 2021-2025 [155], [156]. In terms of a community-level health cadre, there are simply not enough BHWs in the country, but despite this, we see a proliferation of community health workers for different diseases, as mentioned in the Coordination section. Given much of these initiatives are funded by institutional donors, there should be a commitment to fund the BHI and the package of services given this will ensure longer-term sustainability.

Professional membership associations, such as the South Sudanese Nursing and Midwives Association (SSNAMA) and the Association of Gynecologists and Obstetricians of South Sudan (AGOSS) have worked to address the growing loss of skilled professionals through ongoing support to members in the form of trainings and more sustainable solutions [157], [158]. These solutions have included task-shifting, as defined by the WHO as the “rational redistribution of tasks among health workforce teams,” which has been essential in South Sudan where there is a shortage of qualified human resources [159]. Given the maternal mortality and morbidity rates highlighted in the previous sections, a continued investment in these specializations is essential. However, the ability to incentivize individuals to stay within the public health system remains challenging. Violence toward medical professionals has taken a heavy toll on their mental health and psychological well-being and has further disincentivized those remaining in the health field [160]. One nurse captured the plight of medical staff and the difficult choices they must often make given the demanding, and often dangerous, working environments they operate in:

*“You know that people [in South Sudan] are traumatized [...] I wish there was a project addressing the psychosocial issues of South Sudanese, because we have been in this war, the time of war, and some of us—like me, I was born during the time. When I was three years, we had to run away and so on. I knew running at that age [...] We [South Sudanese] have piled emotions and trauma [...] We started [mental health support] for our midwives and nurses. We give psychosocial support and healing, and so on; trainings, but we reach very few. Very few really. [...] We are helping them, the providers themselves, because even they are the ones also traumatized, and then the ones who are taking care of the providers—for us, our mandate is helping the providers themselves. When they are helped, they will be able to help the others. It’s really small, but we are doing it [...] But it’s really an issue. When you see things are not happening, and systems are collapsing [...]”* I15—Key Informant, Private Sector (National Association)

## LOCALIZATION

### **Localization is Lifesaving in South Sudan in the Post-Pandemic, Climate Crisis Era**

The need for accelerated progress in the localization arena has become more apparent following the COVID-19 pandemic when most high-income countries turned inward to focus on their domestic responses, while vulnerable communities in fragile states were pushed further toward devastation and economic despair [161], [162]. Furthermore, global humanitarian funding directly to local and national actors during the pandemic period decreased from 3% in 2020 to 1.2% in 2021, which are both far from the global Grand Bargain 2020 target of 25%, as mentioned above [161]–[163]. As with many other fragile settings, the departure of international responders in South Sudan during the

pandemic exposed a clear gap in sustainability with a pronounced need to ensure that local communities are well-equipped with the tools and resources to respond in the face of shocks and stresses, such as COVID-19 or recurrent flooding<sup>4142</sup> [164]. Localization is an important issue in the context of South Sudan, and reflections from stakeholders interviewed outline several weaknesses. While according to the Grand Bargain the definition of “local actors” should encompass “national and local responders comprising governments, communities, Red Cross and Red Crescent National Societies and local civil society”, the complicated operational environment of South Sudan (due to zero-cash policies, the impact of sanctions, and other restrictions) has contributed to serious barriers to engaging local actors, most notably from government [165]–[168]. Despite these operational realities, respondents interviewed provided meaningful examples of how to enable localization in practice rather than theory, including; (i) centering communities in preparedness, (ii) planning and response efforts; (iii) enhancing measures that build and strengthen institutional capacities; and (iv) exploring direct funding streams to local implementers.

### ***Community-Centered Approaches: flood preparedness as a case example of nexus and localization***

Centering communities in preparedness and response efforts has helped shift the narrative from viewing affected communities as beneficiaries or passive aid recipients to one where they are “agents of their own destiny” [169]. A good example of this has been the response to crises in South Sudan, as different approaches were highlighted during interviews that addressed both unforeseen emergencies, such as violence and ethnic tensions along with other recurrent and more predictable climate-related crises. Flood emergencies have had catastrophic consequences for communities and have impacted the ability of humanitarian and development actors to operate and serve these communities [170]. Given such predictable uncertainty, numerous agencies have put in efforts to prepare communities well in advance of these scenarios, with flood preparedness in South Sudan becoming a permanent feature, such as OCHA’s Anticipatory Action approach in South Sudan and the release of \$19 million in 2022 to both the CERF and the SSHF for preparedness and response [171]–[173]. Beyond responding to the immediate impact of floods on communities, there is the need to maintain services for those affected across other sectors, including health, nutrition, and WASH.

The South Sudan Red Cross has taken a more grass-roots approach to preparedness by conducting vulnerability and capacity assessments of communities to determine specific areas of vulnerability and how community members can respond before, during, and after flood emergencies [174]. The approach taken by the South Sudan Red Cross for over a decade has been carried out in close coordination at the county and state level with the RRC, OCHA, UNMISS, and the Inter-Cluster Coordination Group, as these efforts have included developing community contingency action plans where community members are the first responders [175]. Through the vulnerability and capacity assessments, responders are already aware of which households may be vulnerable, including those with persons with disabilities, the elderly, or others who are unable to evacuate in the immediate aftermath. One vital aspect of such preparedness is the pre-positioning of supplies in flood-prone communities, as action plans also entail trainings on how to do small-scale dyke-making and repairs using kits provided along with how to construct water channels or trenches to draw water out of

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<sup>41</sup> I29—Key Informant, National Organization

<sup>42</sup> I2—Key Informant, International NG)

communities. Another element is community-centered early warning systems, which are currently in place for Jonglei State, and other flood-prone regions, to ultimately allow communities to respond in a more predictable and timely manner through activation and utilization of such systems.

### **Strengthening the Institutional Capacity of Local Actors**

Capacity strengthening has been a key area of focus in South Sudan [176]. Many of the capacity-strengthening efforts to date highlighted by respondents have been short-term, one-off trainings rolled out during the implementation of a grant. Capacity strengthening for MOH counterparts and the challenge of regular turnover was also raised as an issue by organizations who worked closely through the secondment of staff to MOH or by providing direct coaching. One respondent highlighted concern around continuity in support due to such turnover in government posts:

*“Like you capacitated somebody for like six months. In the next six months that person is no longer there. The people who are talking about this are county health directors. You work with them for like nearly six months, three months sometimes. Then this person is out of the office. You have to start with a new county health director again. You have to push, capacitate team and all that. In next six months he's out of the office, so this is really challenging [...] You keep training people that usually go out of the system.”* I30—Key Informant, Private Sector (International Service Provider)

Partnership between N/LNGOs and INGOs or UN agencies was another model for strengthening capacity. However, when examining how many direct partnerships existed between UN agencies and LNGOs in South Sudan, these were limited. The bulk of partnerships of UN agencies were with INGOs and a select few N/LNGOs. As mentioned above, several donors have released strategies guiding engagement with local actors in the past few years, including USAID, ECHO, and FCDO [177]–[179]. When asked about progress regarding more international-local partnerships, one UN official referenced concerns around multiple issues including transparency, trust, accountability, and as it relates to humanitarian principles, independence of LNGOs, from political entities or non-state actors as one UN official highlighted:

*“And we try as much as possible to get local NGO to implement some of the some of the interventions that are put together [...] There are challenges that also comes to that. Number one is the issue of accountability and transparency. So, we have what we call a framework that whatever local NGO, we need to engage is to go through that framework for engaging non-state actors.”* I10—Key Informant, UN Agency

Frustration on the part of some N/LNGOs was apparent, as one respondent felt local organizations got stuck in long-term capacity strengthening, often over years and even decades, without ever moving to a phase of being considered capacitated:

*“Generally, in South Sudan, there's only one word they are talking about and that's that national NGOs doesn't have 'capacity.' This had been for more than 25 years. The national NGOs have no capacity. Okay, it's okay, but even international NGOs have been here more than 30 years, so they're even unable to build a capacity for the national. Because one of their roles is to build the capacity of the national. You look at this period and up to now, you're saying this person, this*

*organization has no capacity. Now whose mistake is here, right?"* I18—Key Informant, National NGO

### **The “Capacity Building Paradox” and Direct Funding to N/LNGOs**

Closely linked to building institutional capacity was the issue of direct funding to N/LNGOs. As with many other contexts, the “capacity building paradox” as we refer to it was at play in South Sudan—essentially, the majority of N/LNGOs were unable to directly access donor funding as they did not have the capacity, but without direct funding, they could not build their capacity in a meaningful way. Most institutional donors interviewed in South Sudan confirmed that they did not channel any funds directly to these organizations. This has been the case for both development and humanitarian funding to health actors. As mentioned above, limited progress in this area in South Sudan mirrors that of global trends of direct funding to N/LNGOs [163]. Although these funds may ultimately be channeled to downstream N/LNGO partners, the issue of the direct funding and limited scope of this mechanism in South Sudan came up in multiple interviews. There has been a focus on funds for “technical trainings” aimed at improving service delivery, rather than including formal capacity strengthening in project budget lines, as one donor emphasized.<sup>43</sup> Additionally, the designation of overhead percentages, often listed as program support costs (PSC) or indirect cost recovery (ICR) rate in grant budgets of local implementing partners were not standardized or consistently applied, according to different donors interviewed during the mission.<sup>44,45</sup> While most INGOs had a standard overhead rate they may apply to the direct funds received from donors, this was not the case for N/LNGOs [180]. The allocation of these funds for sub-implementing partners (sub-IPs), most often local organizations, was not mandated consistently and across the board by donors and UN agencies, nor have N/LNGOs received guidance or sensitization around these policies. A handful of donors and nearly all UN agencies have created standardized policies around indirect cost coverage, such as USAID’s 10% de minimis rate, ECHO’s 7% fixed flat rate, or the UN’s PSC rate varying by respective UN agency [181]–[183]. However, for most of these funds, prime partners still have the discretion for using these within their agencies or the decision-making power to use them for their own organization, since there is no formal mandate to split these with N/LNGO sub-IPs or channel them entirely downward, as noted during different interviews with donors and NGOs.<sup>46,47</sup>

## **REFLECTIONS ON SUSTAINABILITY, RESILIENCE, AND DURABLE SOLUTIONS**

The notions of sustainability, resilience, and durable solutions came up repeatedly during interviews. As discussed throughout the report, a multitude of factors have limited the sustainability of health interventions. These include the blurred lines between humanitarian and ‘development’ assistance, the over-reliance on foreign aid in lieu of investment by the government in the health system, and significant restrictions (e.g., zero-cash policies to MoH staff, the indirect impact of sanctions) for engagement with government counterparts in terms of planning, implementation, and handover

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<sup>43</sup> I20—Key Informant, Donor Agency

<sup>44</sup> I16—Key Informant, Donor Agency

<sup>45</sup> I21—Key Informant, Donor Agency

<sup>46</sup> I21—Key Informant, Donor Agency

<sup>47</sup> I31—Key Informant, National NGO

given the complex operational environment of South Sudan. The compounded effect of these factors has led to a modus operandi that is governed by project cycles, rather than one that is sustainable, and solutions-oriented. There is an explicit need to bring together all actors involved in the response in South Sudan to conceptualize durable solutions, namely by assessing short-, medium-, and long-term implications of programming by humanitarian and development actors. One humanitarian donor captures this concept along with the intricate linkages to peace, governance, and the nexus:

*“I mean, we [donor] might have the documents and the legal framework [to work in South Sudan], but in terms of organization, it's not there. So, we need the governance; we need the peacebuilding; we need X, Y, Z to come together and see short-, mid-term, and long-term and see. We can't say, “Yes, we want an exit strategy today.” Even Nexus is new. Come on, we need to be more context-specific in a way. So, another thing is you mentioned Wau [county]. So, Wau is now identified to start looking into what we call durable solutions.”* I12—Key Informant, Donor Agency

Gaps in sustainability and durable solutions have been most visible through the closure of 220 health facilities during the 2022/2023 period, including 10 hospitals [145], [218]. Funding cuts to the Juba Teaching Hospital demonstrate a bleak trajectory for both health service provision and the linkage to higher education and training programs, as emphasized in the Workforce Development section. Early funding from the Multi-Donor Trust Fund to such facilities through 2013 shaped an optimistic outlook and investment in the health system, including rehabilitation, reconstruction, and other efforts that address health infrastructure [166]. Nearly a decade later, such optimism has dwindled, and contextual realities have altered the viability of the health system given the operational red lines that exist in South Sudan.<sup>48</sup> Approaching 2024, this current state of affairs provides invaluable lessons on handover and transition planning and exposes gaps in how international actors navigate such environments, while inadvertently perpetuating unsustainable approaches. There is the need to work with government health technocrats in a more intentional and concerted manner, exploring avenues to involve them in decision-making, providing incentives to health cadres, and ensuring financial support for essential running costs such as office space, internet, vehicles, and trainings. Providing incentives and hiring staff outside of the MoH for core positions has created a parallel workforce that is unsustainable. Without efforts or plans to address these issues through a systematic approach over time, there will not be a trained and competent workforce for the government to take over when the time is feasible to do so. Such measurable transitional plans should be put in place for the short, medium, and long term for all humanitarian and development projects.

Moving beyond such upstream factors that influence sustainability and resilience, communities are at the heart of such implications. Closely tied to the recommendations in the Localization section, communities should be involved and at the forefront of preparedness and response efforts. Such efforts should include appropriate planning so that community members are trained so that they can continue their work during periods of crisis where accessibility is often limited. Logistical and physical barriers should be addressed, including the ability to transfer funds to community responders and provide supplies before crises occur (including decentralized stockpiles and alternative supply chains), respectively. Investing at a more grassroots level will help shift from the current over-reliance

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<sup>48</sup> I1—Key Informant, National NGO

on the humanitarian sector and improve the continuity of services. One field coordinator reflected on the need for communities to adopt a development and ‘resilience mindset’ as a necessary step to moving away from reliance on assistance:

*“Even without humanitarian assistance, people should be more resilient because one of the biggest problems now, South Sudan is one of the countries that is [fueled] by humanitarian assistance [...] I see the complete two to three generations are being subjected to life of free food, free humanitarian assistance, and then these free humanitarian assistance also make them not to be tenable, dependent too much [...] Sometimes people need to be preparing the way that in case of anything happening, people should be able to have ability to think, to have plan B, plan three because it happens all over the world. Resilience means that to me, for example, if I have my job is going to end in January, I'm going to be shocked because I used to earn salary, but now resilience means to me I have to prepare my mindset now. What am I going to do afterward? Am I going to buy a fishing net? Actually, I don't have a job, so I go to the nearby river and fish. Am I going to be a hunter? What other job am I going to do? Am I going to make a small farm like a cash crop for myself to sustain my family? It's resilience.”* I41—Key Informant, International NGO

The desire of communities to move towards more long-lasting solutions away from humanitarian assistance was relayed in countless interviews. The nature of South Sudan provides a prime example of a diverse context with both fragile and stable settings, where the latter can pave the way for longer-term investment. Communities, particularly youth, are at the crux of this solution, as aid reliance has had generational implications.<sup>49</sup> One humanitarian donor relays the aspiration shared by one such community:

*“Recently, our team went to Wau [...] for a monitoring visit and they saw a massive need [for both humanitarian and development activities] to continue. They've seen people who are trained on life skills. For example, mechanics. There are some training centers that were established, and farming to reduce malnutrition. So many activities that was happening in this point in time. The authorities there [...] clearly say that these are the kinds of activities they want, not just humanitarian. They need development activities because Wau is peaceful. If you look at [this part of] South Sudan, it's relatively calm. They don't have that level of insecurity compared to the other locations. So, they think South Sudan needs that. Second, engaging the youth is very key [it is] 70 percent of the population. If you don't train them and keep them idle, they'll definitely go and find other ways to just keep themselves busy.”* I20—Key Informant, Donor Agency

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<sup>49</sup> I41—Key Informant, International NGO

## RECOMMENDATIONS

Recommendations by Thematic Area	Target Stakeholder
<b>SERVICE PROVISION</b>	
<p><b>Recommendation: Explore ways to enhance FP services</b></p> <p>Due to the very low contraceptive prevalence, MIHR and other programs have understandably focused on expanding FP. There has been an over-reliance on facility-based FP services. Since most of the population resides in rural areas, MIHR and other actors have understandably focused on more community-based, mobile services to provide FP. Yet, there have been significant challenges in achieving such outreach. Furthermore, there is a need to look at the broader landscape of primary health care and see how FP can be better prioritized and accepted amongst various actors. Efforts are needed to better integrate the numerous FP initiatives within humanitarian interventions and existing MCH services at the facility- and community levels to ensure the sustainability of FP programs.</p>	<p>✓ MOH</p> <p>✓ Implementing Agencies</p>
<p><b>Recommendation: Promote SRH self-care interventions</b></p> <p>Building off the supply chain recommendations, there should be a greater push for SRH self-care interventions, given the frequency of service interruption due to emergencies or prolonged absences from health facilities. This was particularly the case for FP interventions, including long-acting reversible contraceptives, such as injections (e.g., Sayana Press, Depo-Provera) and hormonal implants (e.g., Jadelle, Implanon), particularly during flood and harvesting seasons for women who desired longer-term options. Although utilization rates indicated low uptake of such methods, concerted efforts to address these barriers through social and behavioral change should be undertaken; these include ensuring enhanced awareness around such interventions and the associated risks and misconceptions, all delivered in a culturally sensitive and nuanced manner.</p>	<p>✓ Implementing Agencies</p>
<p><b>Recommendation: Establish fewer “niche” programs and instead bring them to scale</b></p> <p>During the field visits, there were several novel and innovative programs showcased that were relatively small (niche) but potentially significant in impact. These included flood preparedness, FP, and economic recovery/livelihood interventions. While these programs and pilots have tremendous potential, there should be more strategic thinking about how (and if) these programs can be brought to scale in South Sudan at this time. Given the operational and financial constraints and sustainability challenges in South Sudan at present, donors need to work more closely with the</p>	<p>✓ Implementing Agencies</p> <p>✓ Donors</p>



<p>government and actors on the ground, including the communities, to limit the number of pilot programs that are implemented in South Sudan at present, while focusing on the core elements of health system preparedness and response with an emphasis on sustainability.</p>	
<p><b><i>Recommendation: Develop and enhance national human resource strategies for development, recruitment, and retention at health facilities and the community level, including the hiring of health workers within the MOH system, while advocating for the government to make timely salary payments to MOH staff</i></b></p> <p>We advocate for the government to pay MOH staff salaries on a regular, timely basis. Some NGOs that hire staff outside the system have created a parallel workforce. There should be a clear plan for how staff hired outside the system will later be incorporated into the government health system. Given the numerous funding cuts observed, many such projects have shown to be unsustainable with potential harmful, long-term implications for staff and communities.</p>	<ul style="list-style-type: none"> <li>✓ <b>MOH</b></li> <li>✓ <b>Implementing Agencies</b></li> <li>✓ <b>Donors</b></li> </ul>
<p><b><i>Recommendation: Implement and streamline equitable incentive payments to the health workforce</i></b></p> <p>While many donors have implemented restrictions and zero-cash policies that prevent direct payment to the health workforce, there should be more rigorous compliance by the government to pay salaries for staff. In addition, there should be a commitment by donors and NGOs operating in South Sudan to comply with the circular for incentives for MOH and NGO staff to address inequitable, discrepant salary/incentives in place. A streamlined structure will help to minimize the creation of a parallel workforce through the humanitarian and development sectors and instead sustain a national/local health workforce.</p>	<ul style="list-style-type: none"> <li>✓ <b>Implementing Agencies</b></li> <li>✓ <b>Donors</b></li> </ul>
<p><b><i>Recommendation: Streamline and consolidate the myriad of community-level cadre and move towards implementing the Boma Health Initiative</i></b></p> <p>The government has developed a clear and accepted Boma health strategy and plan that has not been sufficiently implemented due to inadequate funds, amongst other factors. All actors should ensure that the Boma Health Initiative, a government flagship program, is implemented. Since serious health system sustainability issues exist, a more intentional, localized effort should entail investment in nationally-led initiatives. This recommendation will require other parallel programs to modify their community outreach and put funding and interventions into the BHI. Given the duplication in many functions of the community-level cadre, there should be regular stock-taking exercises to determine how to streamline personnel, including those working alongside BHWs, as it is more cost-effective and reduces duplication. A focus</p>	<ul style="list-style-type: none"> <li>✓ <b>Implementing Agencies</b></li> <li>✓ <b>MOH (at different levels)</b></li> </ul>

<p>by all actors on implementing the BHI would allow for standardization and improved community health outreach across the country. This will have implications for other services added to the basic package under the BHI, such as FP, and will complicate the rollout of the BHI if other organizations continue to add such services outside the agreed-upon BHI package.</p>	
<p><b><i>Recommendation: Re-evaluate the supply chain “push system” and move toward a demand-driven response, including a review of policies and guidelines</i></b></p> <p>Given that the current “push system” in South Sudan is not consumption-driven, the efficiency in supply chain management should be re-evaluated to ensure that delivery and procurement of supplies are based on demand and can accommodate stock-outs, particularly during emergencies. There is a need to move beyond some pilots towards a real-time data collection and response system for supply chain management. Further challenges to ensure a demand-driven FP supply chain system relate to capacity, infrastructure, and resistance to information sharing. Integrated call centers for FP are one such interim effort that can be built on to retrieve data and make better-informed decisions that align with procurement and consumption/utilization rates. Access to timely, accurate information on FP usage across all distribution sites will allow for more effective utilization of resources. Real-time trends documented and reported by geographic location, will allow for a more tailored approach to FP interventions. This may include identifying and addressing underlying factors, such as barriers to uptake. Much of this may be accomplished through a review of existing policies and guidelines that support the supply of life-saving commodities, FP distribution to non-MOH counterparts, the private sector, and access to FP methods at other non-health venues (e.g., community centers, etc.).</p>	<ul style="list-style-type: none"> <li>✓ <b>Implementing Agencies</b></li> <li>✓ <b>MOH</b></li> <li>✓ <b>Private Sector</b></li> </ul>
<p><b><i>Recommendation: Conduct regular service rationalization exercises for MCH/SRH services</i></b></p> <p>Given the reality of funding cuts, there should be a concerted effort between and across humanitarian and development actors to assess existing MCH/SRH services and gaps then prioritize specific interventions according to impact and cost. This should entail a rationalization exercise for all facilities and community-level interventions with a potential re-distribution of services to ensure MCH/SRH is integrated within primary health care. This will ensure that MCH/SRH services better align with population demands, the effectiveness of interventions, and their costs. Such difficult decisions will likely require different stakeholders to shift, modify, or downsize their existing operations. It will also promote a greater push towards sustainability. Other means of assessing the impact of services and coverage on mortality may be used,</p>	<ul style="list-style-type: none"> <li>✓ <b>Implementing Agencies</b></li> <li>✓ <b>Donors</b></li> </ul>

including the Lives Saved Tool (LiST), a mathematical modeling tool for use in low- and middle-income settings.	
<b>INSTITUTIONAL ARCHITECTURE</b>	
<p><b><i>Recommendation: Address HDN barriers at the institutional level and across agencies</i></b></p> <p>There should be a greater effort to break down institutional siloes and harmonize approaches within/across dual and multi-mandate agencies (e.g., humanitarian, development, peace). While these structures are often deeply entrenched, there should be a concerted effort, starting from leaders at headquarters, to establish directives to implement the HDN and provide operational guidance to country offices. This will require examination of organizational structure, human resources, funding streams, and reporting requirements, among many other factors. A directive would need to occur from the organization as to the importance and aims of addressing HDN, followed by a specific standard operating procedure should exist as to how such approaches would be implemented at headquarters, regional and country levels. Examples of how this has been done in other settings should accompany the SOP.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ INGOs</li> </ul>
<b>LEADERSHIP</b>	
<p><b><i>Recommendation: Ensure more focused, strategic, and practical ways to engage with and include government health technocrats, particularly at the state and county levels, in decision-making to improve ownership and sustainability</i></b></p> <p>Despite limitations of direct funding to the government in South Sudan, there are ways to ensure that technocrats in the government at all levels are provided sufficient support from a technical standpoint to be included in a substantial manner; this is key to ensure their input is included in all decisions and for the sustainability of the health system in the future. This is also essential to help retain government staff at the sub-national (e.g., county) level. A common framework for engagement will enable long-term sustainability when the government eventually takes over such functions, particularly within FP/RH/MNCH.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ INGOs</li> </ul>
<b>FINANCING</b>	
<p><b><i>Recommendation: Consider consolidating the development funding mechanisms</i></b></p> <p>Consolidation of the two largest health development funds in South Sudan into one large fund would improve efficiencies and allow for more flexibility as</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> </ul>

<p>funding changes over time. It would also be one coherent system, and hence, easier for the government to eventually lead and manage, which is the long-term goal of all actors.</p> <p>NOTE: We are aware (and pleased) that this recommendation is actually occurring, and that the multi-donor trust fund will be governed by the World Bank and UNICEF will be the fund manager.</p>	
<p><b><i>Recommendation: Integrate short-term and longer-term (development) funding and programming at the state level</i></b></p> <p>Intentional strategies and programs funded at the state level should have clear, practical transition strategies and indicators of success for the short-term humanitarian programs to hand over to the development programs. For example, integrating cross-cutting emergency funding is one approach to ensure coherence and flexibility to transition between humanitarian-development scenarios (more indicators will be proposed during the latter half of this project).</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ I/NGOs</li> </ul>
<p><b><i>Recommendation: Fund early recovery and development programs in geographic areas primed for development and pilot various HDN programs in these areas</i></b></p> <p>Despite the instability and challenges that occur throughout much of South Sudan, there are counties within states, and some states that have remained relatively stable. These areas are suitable for more comprehensive programs to ensure that funds are used for early recovery.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> </ul>
<p><b><i>Recommendation: Invest in more preparedness planning exercises for humanitarian actors given recurrent crises, and better integrate cross-cutting and contingency funding streams from development actors</i></b></p> <p>Current emergency/contingency funding is highly reactive, and there is a need to invest in more preparedness planning given the predictability of emergencies (e.g., seasonal floods, droughts). Regular stock-taking of existing funding streams by both humanitarian and development actors should occur in a coordinated fashion to ensure accelerated activation and more cross-cutting integration within existing programming for <i>both</i> humanitarian and development assistance.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ Humanitarian Actors</li> <li>✓ Development Actors</li> </ul>
<b>COORDINATION</b>	
<p><b><i>Recommendation: Consolidate redundant coordination fora and reinvigorate the HDpN coordination body with increased political buy-in with clear objectives and tangible outcomes</i></b></p>	<ul style="list-style-type: none"> <li>✓ MOH</li> <li>✓ Donors</li> </ul>

<p>There are currently far too many coordination fora in South Sudan, many of which are siloed and duplicative, with limited buy-in. Most coordination meetings appear to focus on information-sharing and are not sufficiently action-oriented. Beyond technical coordination bodies, there is a fledgling HDpN coordination body that lacks sufficient funds and political buy-in. This body should be a strategic nexus coordination group that builds on the existing nexus approach put in place by the RC/HC across the humanitarian, development, and peace sectors.</p>	<ul style="list-style-type: none"> <li>✓ UN Agencies</li> <li>✓ I/NGOs</li> <li>✓ Clusters</li> <li>✓ Private Sector</li> </ul>
<p><b><i>Recommendation: Develop coherent and complementary humanitarian and development health information systems to follow transitions between both according to evolving contexts</i></b></p> <p>There is the need to have agreed-upon data collection systems and a certain amount of financial and program standardized indicators at the county and state levels amongst humanitarian and development actors, including input, output, and impact, to have a more cohesive picture of what is occurring from hospital to community. Preparedness plans should include humanitarians during their development and include anticipatory action and recurrent shocks and stresses. Specific FP/RH/MNCH indicators should be included that consider context and movement between emergency to comprehensive indicators (and back) depending upon the situation.</p>	<ul style="list-style-type: none"> <li>✓ Humanitarian Actors</li> <li>✓ Development Actors</li> <li>✓ Clusters</li> </ul>
<p><b><i>Recommendation: Establish a comprehensive mapping initiative across humanitarian and development sectors that includes geographic, financial, implementation, and sector details</i></b></p> <p>A comprehensive mapping should include four key elements from the geographic, financial, implementer, and sector standpoints. While already in place within the humanitarian sector, it should be expanded to adopt a nexus focus and gain a comprehensive picture, given the large degree of overlap in funding and activities. This routine exercise should lead to a rationalization of implementing agencies and partners, enable more efficiency in how many entities are present in each geographic region, and lead to transition plans from short to longer-term programs.</p>	<ul style="list-style-type: none"> <li>✓ MOH</li> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ I/NGOs</li> <li>✓ Clusters</li> <li>✓ Communities</li> </ul>
<p><b>LOCALIZATION, SUSTAINABILITY, RESILIENCE, AND DURABLE SOLUTIONS</b></p>	
<p><b><i>Recommendation: Accelerate localization commitments through enhanced policies and more egalitarian partnership approaches</i></b></p> <p>Progress toward localization in South Sudan has been significantly stunted compared to other contexts for the reasons mentioned in this report. Investment in the two critical areas outlined below will help strengthen</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ INGOs</li> </ul>

<p>institutional capacity and empower local actors through concrete financial measures.</p>	
<p><b><i>Recommendation: Ensure capacity strengthening plans are meaningful and developed in collaboration with N/LNGOs to accurately reflect their needs; Ensure donor investment in such plans</i></b></p> <p>There is a need to ensure that capacity strengthening plans are developed in close collaboration with N/LNGOs, rather than imposed on the N/LNGO by the donor or prime agency. This will first require that all N/LNGO grant agreements through prime/intermediary INGOs and UN agencies have explicit budget lines for capacity strengthening throughout the program cycle. There is a need to move beyond short-term, one-off training models for technical service delivery and a need to review and re-assess the coverage of critical support functions from a compliance standpoint. Essential functions include coverage for human resources, finance, logistics, risk management. Finally, have a clear capacity strengthening plan with metrics and reporting to ensure important and sustainable strengthening is undertaken.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ INGOs</li> <li>✓ N/LNGOs</li> </ul>
<p><b><i>Recommendation: Create and/or enhance donor policies for program support costs and indirect coverage to N/LNGOs via their prime partner agencies</i></b></p> <p>Building off of the previous recommendation; all donors should establish and implement program support costs and indirect cost rates policies for budgets for all partners downstream, including N/LNGOs. This recommendation includes key institutional donors and/or pass-through prime agencies such as UN agencies and INGOs. There is a need to ensure complete sensitization, awareness, and education around program support costs and indirect cost rates for N/LNGOs to ensure an equitable, rights-based approach to partnership. There is also a need to ensure that those funds are channeled and shared with N/LNGOs who do not have the same operational reserves and are not able to institutionalize entirely in the absence of support costs.</p>	<ul style="list-style-type: none"> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ INGOs</li> </ul>
<p><b><i>Recommendation: Enhance measures of sustainability, resilience, and durable solutions specific to the South Sudan context and implement existing strategies and plans so that such aims may materialize</i></b></p> <p>While the government of South Sudan has developed both a National Development Strategy and a Development Plan, many aspects of these have not been implemented. Significant challenges exist due to the fragility across and within different parts of the country combined with transparency issues. These have contributed to the need for humanitarian assistance instead of</p>	<ul style="list-style-type: none"> <li>✓ MOH</li> <li>✓ Donors</li> <li>✓ UN Agencies</li> <li>✓ I/N/LNGOs</li> <li>✓ Communities</li> </ul>

longer-term and sustainable development assistance. At the grassroots level, communities are central to sustainability and resilience efforts. Concrete measures should be taken to ensure that logistical and financial barriers are addressed when engaging communities in preparedness, planning, and response. These include the active involvement of communities in planning and preparedness efforts by humanitarian actors and disaster management authorities at the state and county levels, as did occur more recently in flood-prone communities. There should also be explicit and intentional efforts to engage communities in program design and development, rather than following the approval for implementation by donors. This will ultimately enable communities to conceptualize and shape interventions that are considered important for their immediate and long-term needs and allow for a shift to more sustainable solutions.

Realistic and feasible long-term viability and sustainability plans for the health system are needed. For these to be achieved, there must be a concerted effort with practical steps to include government health technocrats. As mentioned in recommendations above, for this to work, governments must pay their salaries on time and they should also receive financial incentives to improve retention, rather than hiring a parallel workforce. Furthermore, there is a need to support basic infrastructure for MOH counterparts at the national level, and more critically, sub-national levels (e.g., coverage for office space, internet, vehicles, and trainings). Lastly, the creation and documentation of measurable transition plans from short-term to longer-term humanitarian and development projects are needed to ensure sustainability (as stated above).

## LIMITATIONS

This study has several limitations. This includes different forms of bias given the nature of the research, including selection bias, recall bias, and implicit bias [184], [185], [186]. Closely tied to addressing these biases, reflexivity was an important consideration for the researchers of this study [184]. Ongoing reflexivity was a necessary exercise and included locating the positionality of the research team and that of respondents relative to the research focus given there may have been a degree of familiarity between researchers and interviewees who were both practitioners in the sectors of focus [187]. While different measures were taken beforehand to limit convenience sampling through a purposeful sampling approach, there were respondents added during the data collection period on-site during the visit (i.e., snowball sampling) [184]. The sensitive nature of the topics explored may have also contributed to a degree of censorship for what was deemed appropriate to discuss in the confines of the South Sudanese context along with potential self-censorship by respondents. Discussion of the HDN may have also been deemed too broad of a topic and its application to FP/RH/MNCH was often considered less of a priority given there were so many critical, overlapping issues in South Sudan at present. Lastly, there were logistical, financial, security, and time constraints that impacted the ability of the research team to examine the application of the HDN in different geographic regions in South Sudan beyond Juba (capital and county) and Bor County in

Central Equatoria and Jonglei states, respectively. It is important to note that the findings of this of this case study may not be representative of all areas visited or those geographic locations beyond where the research was conducted.

## CONCLUSION

This case study demonstrates the complexity of how to operationalize the humanitarian-development nexus and its application to FP/RH/MNCH interventions in a fragile and constantly evolving context such as South Sudan. The absence of peace and ongoing conflict have contributed to chronic insecurity and political instability, leading to recurrent relapses in fragility across and within different parts of the country. Given South Sudan's heightened vulnerability to these shocks and stresses, the humanitarian situation has become exacerbated, and progress toward both recovery and development remains stunted. Due to the extremely fragile context, development funds and programs for health in South Sudan are complex and complicated to implement. Restrictions in the operational environment mentioned above have made it very difficult for the international community to work with the government to deliver health services in a sustainable manner. This is critical given South Sudan has the highest ratio of maternal mortality and lowest contraceptive prevalence rates relative to global averages. Investment in FP has been linked to the SDGs and a stronger linkage between FP and maternal health outcomes has been demonstrated, with FP deemed a "lifesaving" intervention, particularly for communities affected by conflict, natural disaster, and displacement who may have limited access to quality maternity services, as is the case in South Sudan.

Institutional architecture is a critical barrier to a meaningful nexus approach. This relates not only to the nexus but also to issues such as decolonization and localization. Both humanitarian and 'development' health activities in South Sudan have been primarily humanitarian in nature, with the basic objective to keep basic health services functioning while responding to various stressors such as flooding, conflict, forced displacement, and COVID-19. In 2023, humanitarian needs continued to increase across the country despite humanitarian funding levels remaining the same as years prior. Consequently, the need for development and humanitarian actors to work more closely together is not just an HDN issue, but essential to ensure humanitarian assistance is used effectively, particularly considering drastic funding cuts from health development donors in 2022/2023.

The multitude of coordination fora and meetings should be significantly consolidated and a dedicated HDpN coordination body should be established. There have been some strides taken in this direction with the Partnership for Peace, Resilience, and Recovery initiative. Other efforts to address gaps in coordination should include the development of coherent and complementary humanitarian and development health information systems with key indicators to follow transitions between the two depending upon contexts. Specific indicators for FP/RH/MNCH should be included that consider context and movement between emergency indicators to more comprehensive indicators (and back) depending upon the situation. Additionally, a comprehensive mapping initiative should be undertaken, which includes a snapshot of four key elements from the geographic, financial, implementer, and sector-specific standpoint across all humanitarian and development stakeholders at the state and county levels.



There should be concerted measures taken to ensure the recruitment, training, and retention of human resources since a strong local workforce is paramount to the success of a viable and sustainable health system. A streamlined, equitable incentives structure will avoid the creation of a parallel health workforce through the humanitarian and development sectors, and instead help sustain a national/local workforce. The current “push system” in the supply chain management in South Sudan is not consumption-driven, and there should be a re-evaluation of the efficiency in supply chain management to ensure that delivery and procurement of FP supplies are based on demand and can accommodate stockouts, particularly during emergency periods. With the reality of funding cuts, there should be a concerted effort between and across humanitarian and development actors to take stock of existing FP/RH/MNCH services and gaps and to prioritize interventions according to impact and cost. This should entail a rationalization exercise for all facilities and community-level interventions with a potential re-distribution of services to better align with population demands, effectiveness of interventions, and their costs. As it pertains to FP services, MIHR and other programs have focused on expanding FP in South Sudan due to poor contraceptive prevalence. Low uptake figures should be re-examined to better understand the reasons behind this phenomenon and the challenges in addressing them. Furthermore, there is a need to look at the broader landscape of health and see how FP can be better prioritized by a variety of actors in the complex context of South Sudan. Efforts are needed to better integrate the numerous FP initiatives within humanitarian interventions and existing MCH services at the facility and community levels to ensure the sustainability of FP programs in the long term. This may also include a greater push for SRH self-care interventions given the frequency of service interruption due to emergencies or long absences from health facilities.

Given the operational constraints and sustainability challenges in South Sudan at present, donors need to work more closely with the government and actors on the ground, including the communities, to limit the number of pilot programs that are implemented at present, while focusing on the basics of health system preparedness and response. Lastly, there is a need to enhance measures of sustainability and resilience, specific to the South Sudan context and implement existing strategies and plans so that such notions may materialize.

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# ANNEXES

## ANNEX A. USAID SOUTH SUDAN COUNTRY ROADMAP

# SOUTH SUDAN

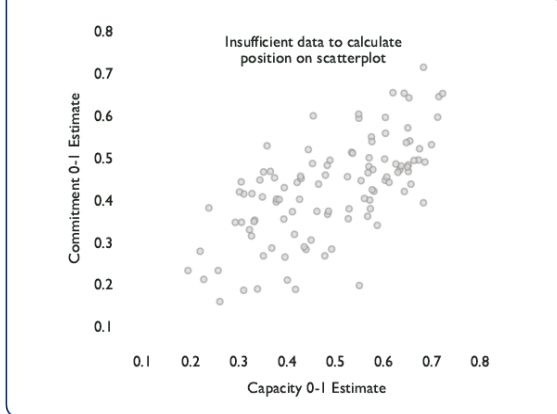
## FY 2023 COUNTRY ROADMAP



### LEGEND

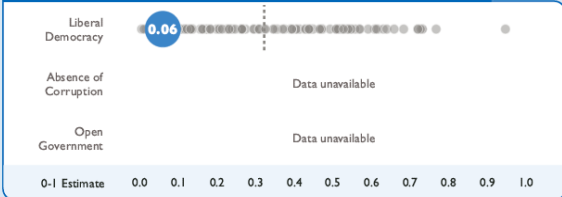


### LOW- & MIDDLE-INCOME SNAPSHOT

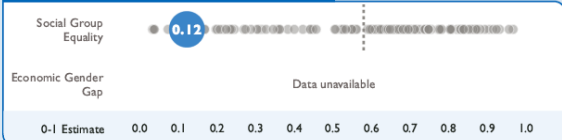


## COMMITMENT

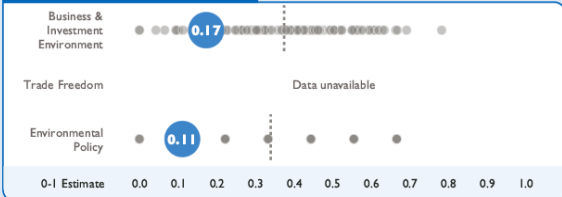
### OPEN AND ACCOUNTABLE GOVERNANCE



### INCLUSIVE DEVELOPMENT



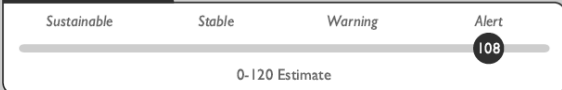
### ECONOMIC POLICY



### RISK OF EXTERNAL DEBT DISTRESS

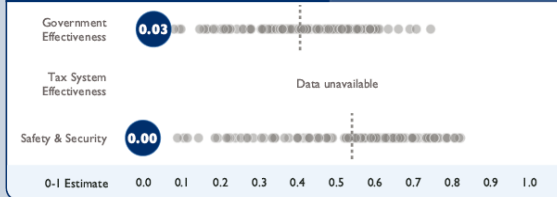


### FRAGILITY

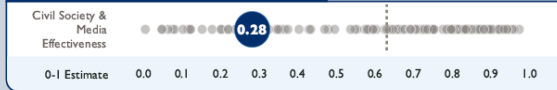


## CAPACITY

### GOVERNMENT CAPACITY



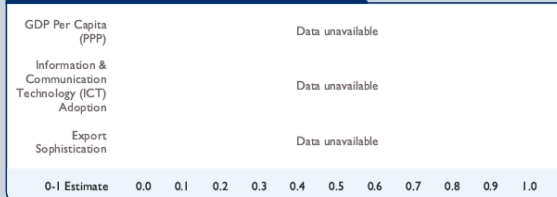
### CIVIL SOCIETY CAPACITY



### INDIVIDUAL CAPACITY



### CAPACITY OF THE ECONOMY





## ANNEX B. KEY DEMOGRAPHIC INDICATORS IN SOUTH SUDAN AND GLOBAL AVERAGES

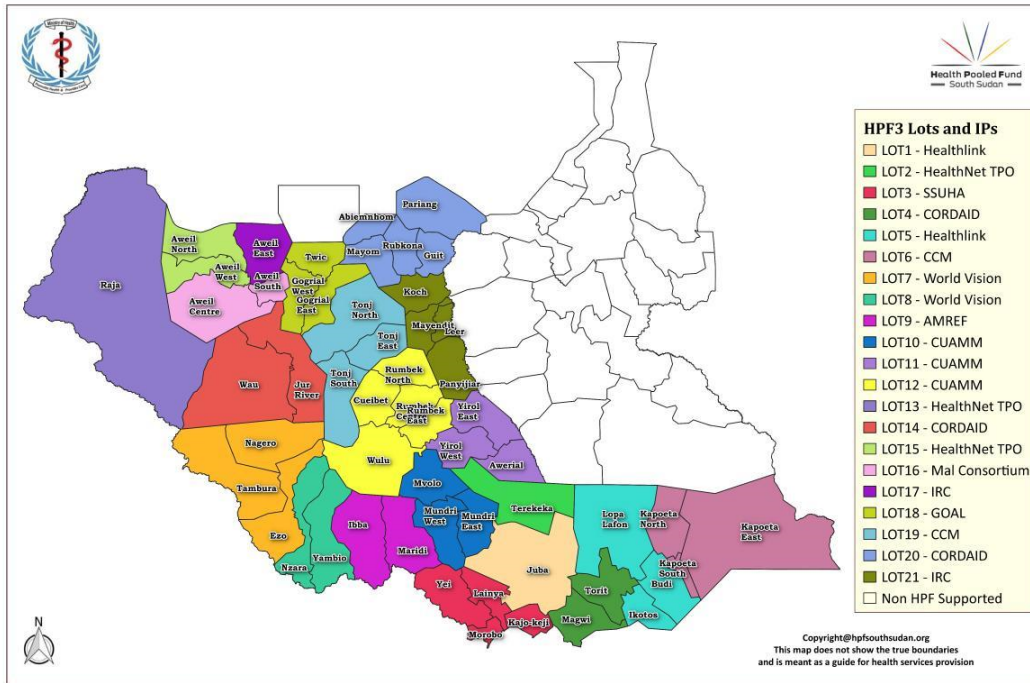
Indicator	South Sudan	Global Average
Population, Total (2023, estimate)	12.1 million	---
Under 5 (U5) Mortality Rate (2021) (# of deaths per 1,000 live births)	90.7	38
Neonatal Mortality Rate (2021) (# of deaths per 1,000 live births)	40	18
Stillbirth Rates (2021) (# of deaths per 1,000 total births)	25.8	13.9
Maternal Mortality Ratio (2020) (# of deaths per 100,000 live births)	1,223	223
Child Immunization Rates, examples (2021) (% of children ages 12-23 months); Measles, DTP	49, 49	82, 81
Percentage of Women (age 20-24) Married/In Union Before the Age of 18 years (2020)	52	---
Fertility Rate, Total (2020) (births per woman)	4.5	2.3
Contraceptive Prevalence, any methods (2010) (% of women ages 15-49)	4	63
Literacy Rate, Adult Total (2018) (% of people ages 15+)	35	87
Unemployment Rate, Total* (2022) (% of total labor force, ILO); *Does not account for informal economy	13	5.8
Human Development Index (2022) (global ranking out of 189 countries)	185	----
Population below International Poverty Line (%) (2016)	80	8
Life Expectancy (2021) (years)	55	73.4
Youth Population (2021) (% of total population)	57	16
Gross Domestic Product per Capita (2015)	\$747.70	\$12,236.60
Access to Health Services (2020) (# of people per one physician)	65,574	625
Access to Safe Water (2021) (% of total population)	40	74
Access to Education (2022) (estimated # of children out of school)	2.4 million	258 million
Food Insecurity (2023) (# of people in IPC phases 4&5, emergency & catastrophic levels)	3.58 million	40 million
Acute Malnutrition Prevalence (2023) (estimated # of women and children)	2 million	57.9 million
Gender-Based Violence Risk (2022) (estimated # of people)	2.6 million	1.3 billion

## ANNEX C. KEY INFORMANT CHARACTERISTICS

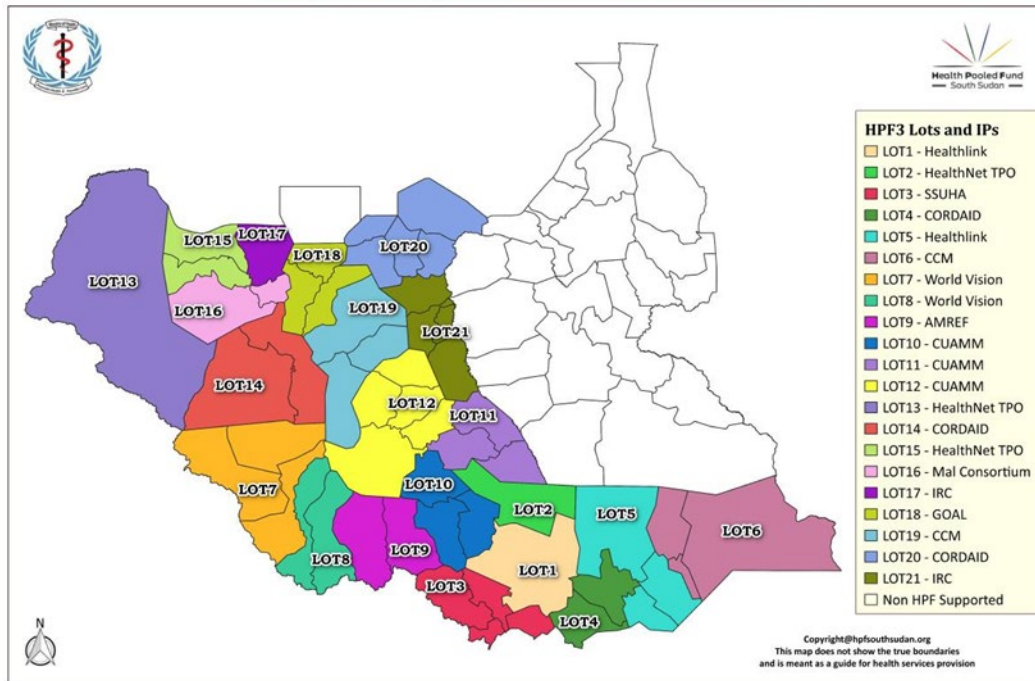
No.	Geographic Location	Organization Type
1	Juba	National NGO
2	Juba	International NGO
3	Juba	International NGO
4	Juba	Private Sector, International Service Provider
5	Juba	National NGO
6	Juba	Private Sector, International Development
7	Juba	International NGO
8	Juba	Donor
9	Juba	UN Agency
10	Juba	UN Agency and Cluster Co-Lead
11	Juba	Private Sector, International Development
12	Juba	UN Agency
13	Juba	Donor
14	Juba	UN Agency
15	Juba	Private Sector, National Association
16	Juba	Donor
17	Juba	International NGO
18	Juba	National NGO
19	Juba	Donor
20	Juba	Donor
21	Juba	Donor
22	Juba	International NGO
23	Juba	UN Agency
24	Juba	Donor
25	Bor	Government/Ministry
26	Bor	Health Facility, Service Provider
27	Bor	Government/Ministry
28	Bor	International NGO
29	Bor	National Organization
30	Bor	Private Sector, International Service Provider
31	Bor	National NGO
32	Bor	International NGO
33	Bor	Health Facility, Service Provider (hired by INGO)
34	Bor	International NGO
35	Bor	National NGO
36	Bor	Government/Ministry
37	Bor	International NGO, Cluster Co-Lead
38	Bor	Boma Health Workers (hired by INGO)
39	Bor	Health Facility, Service Provider (hired by INGO)
40	Bor	Community Health Committee
41	Bor	International NGO

# ANNEX D. MAPS OF HEALTH POOLED FUND 3 COVERAGE BY LOT

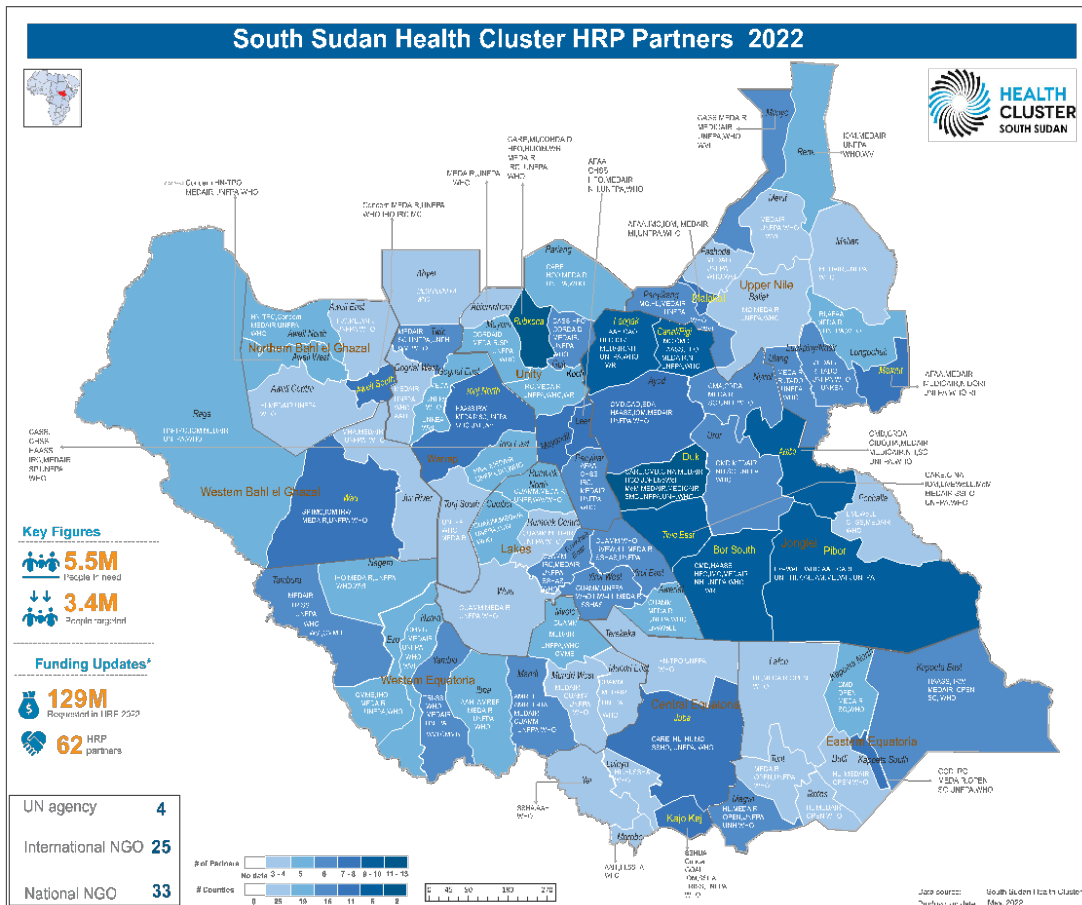
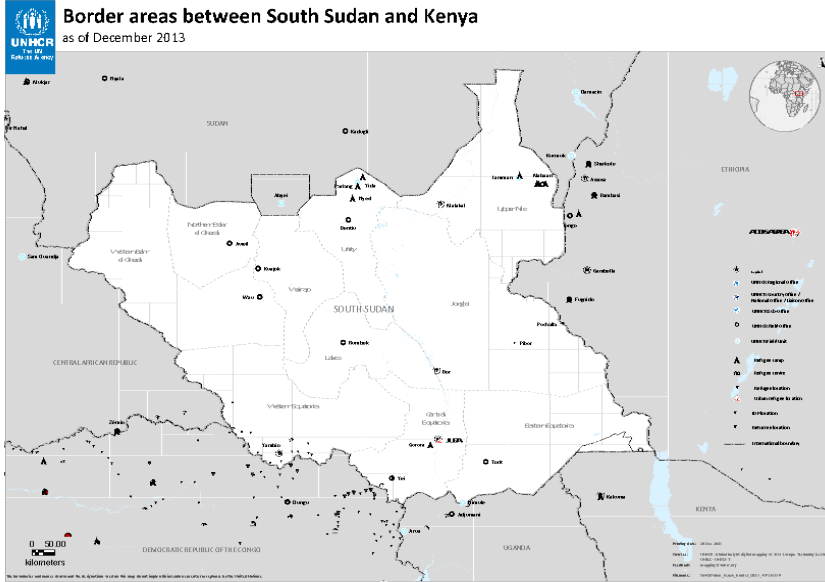
HPF3 SUPPORT TO SOUTH SUDAN: LOTS & LEAD IPs



HPF3 SUPPORT TO SOUTH SUDAN: LOTS & LEAD IPs



# ANNEX E. SAMPLE OPERATIONAL MAPS OF SOUTH SUDAN



# ANNEX F. SERVICE COVERAGE IN JONGLEI STATE FOR ANTENATAL CARE, POSTNATAL CARE, AND EMERGENCY OBSTETRIC AND NEWBORN CARE (BASIC AND COMPREHENSIVE)

Figure 16. ANC Service Coverage

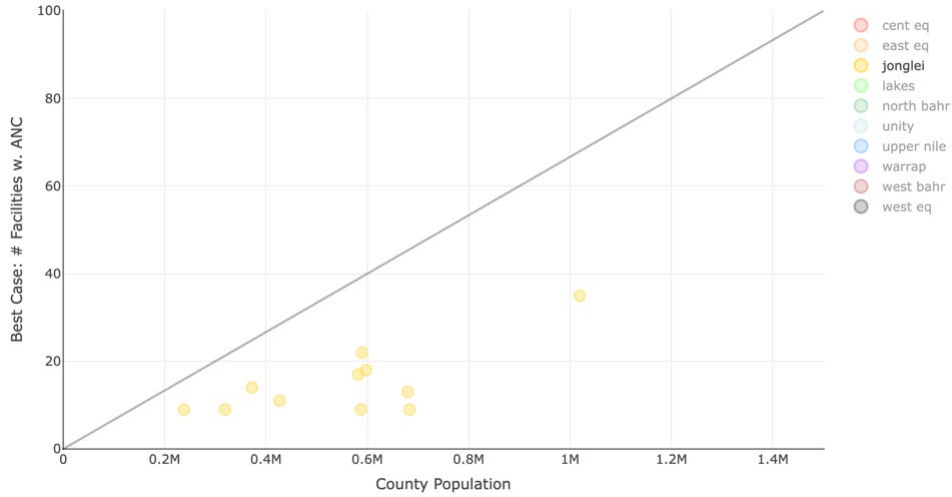
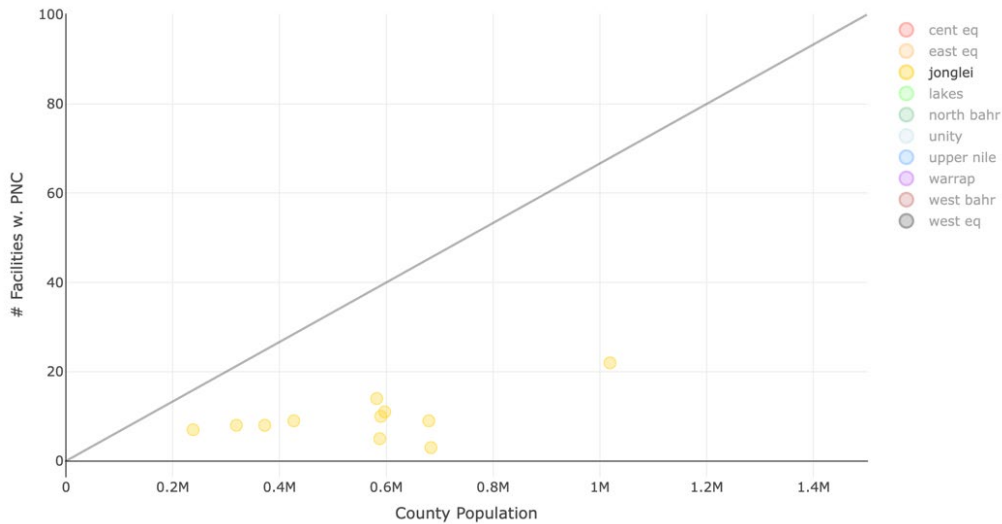
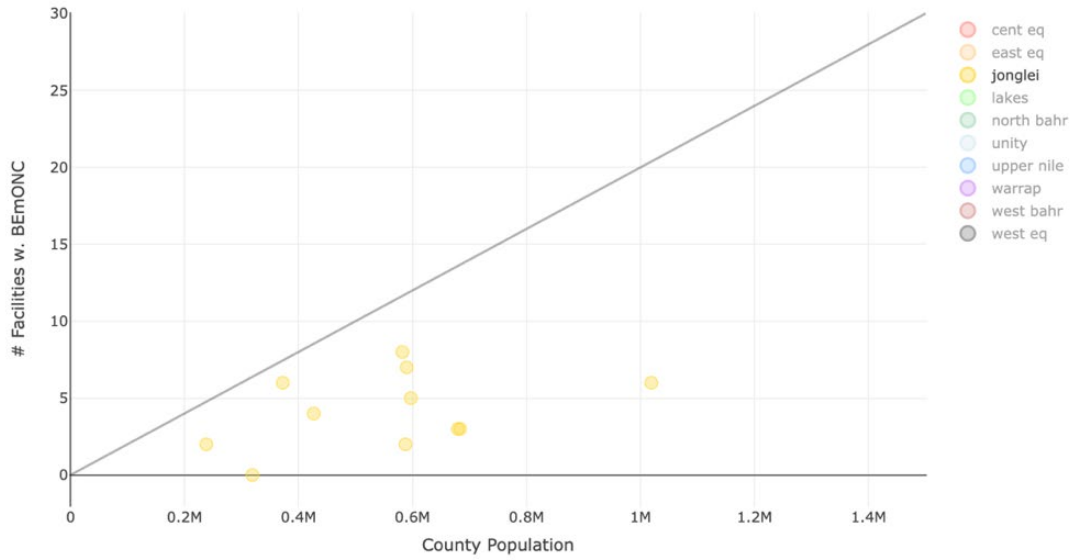


Figure 17. PNC Service Coverage



**Figure 18. BEmONC Service Coverage**



**Figure 19. CEmONC Service Coverage**

