

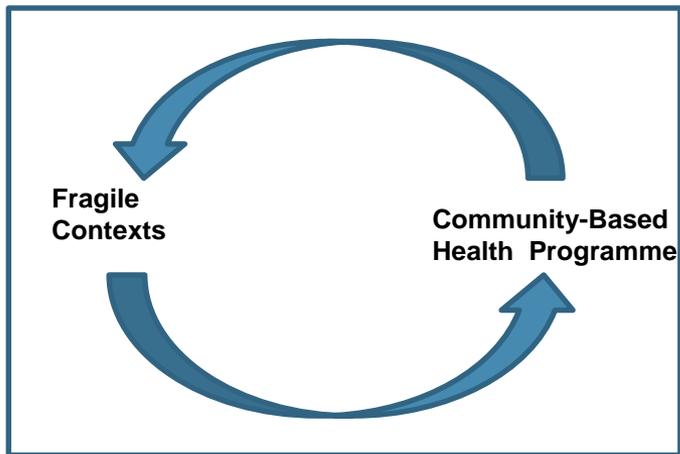


# Interaction between a community-based health programme and the fragile context

## *Lessons learnt from a Swiss Red Cross programme in South Sudan*

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Swiss TPH in collaboration with SRC



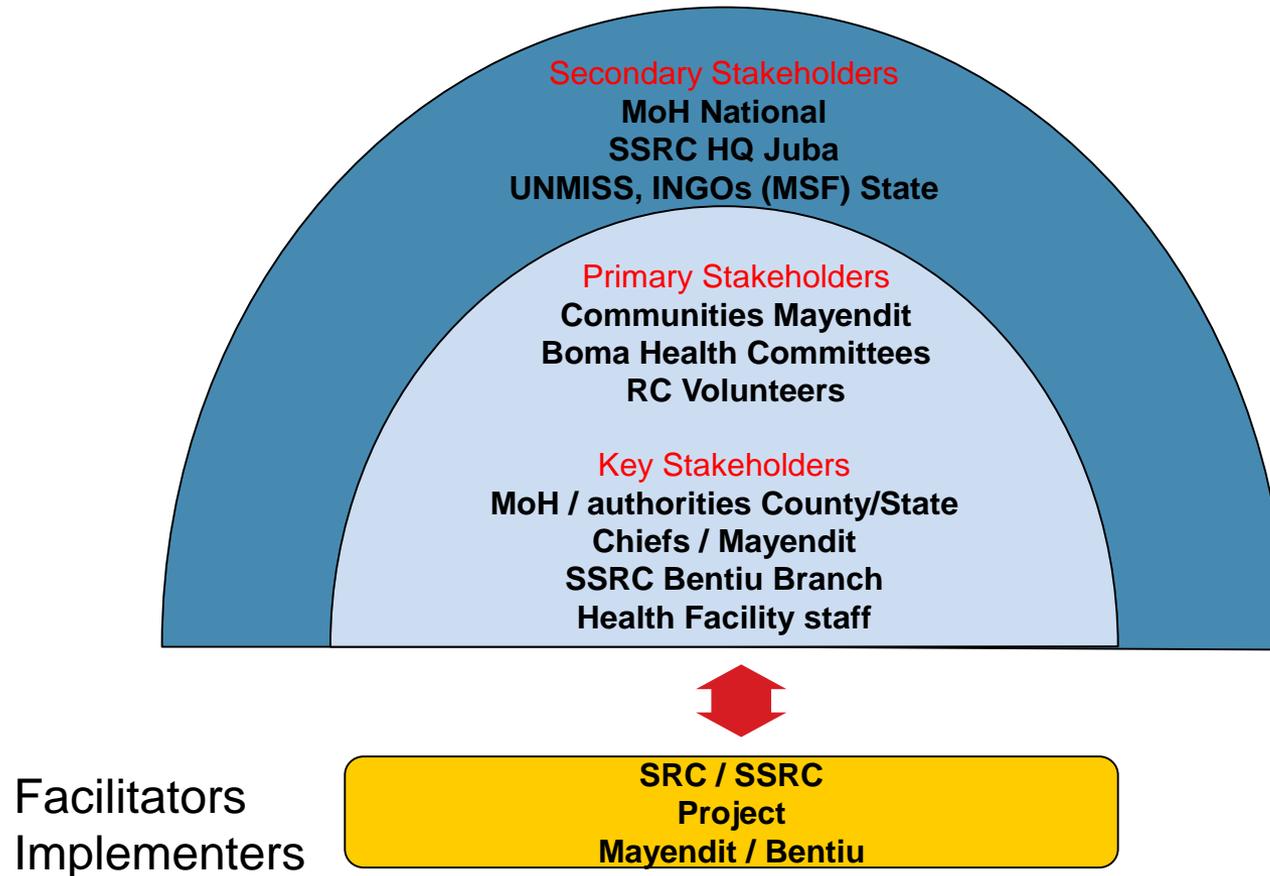


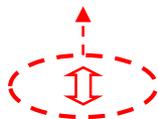
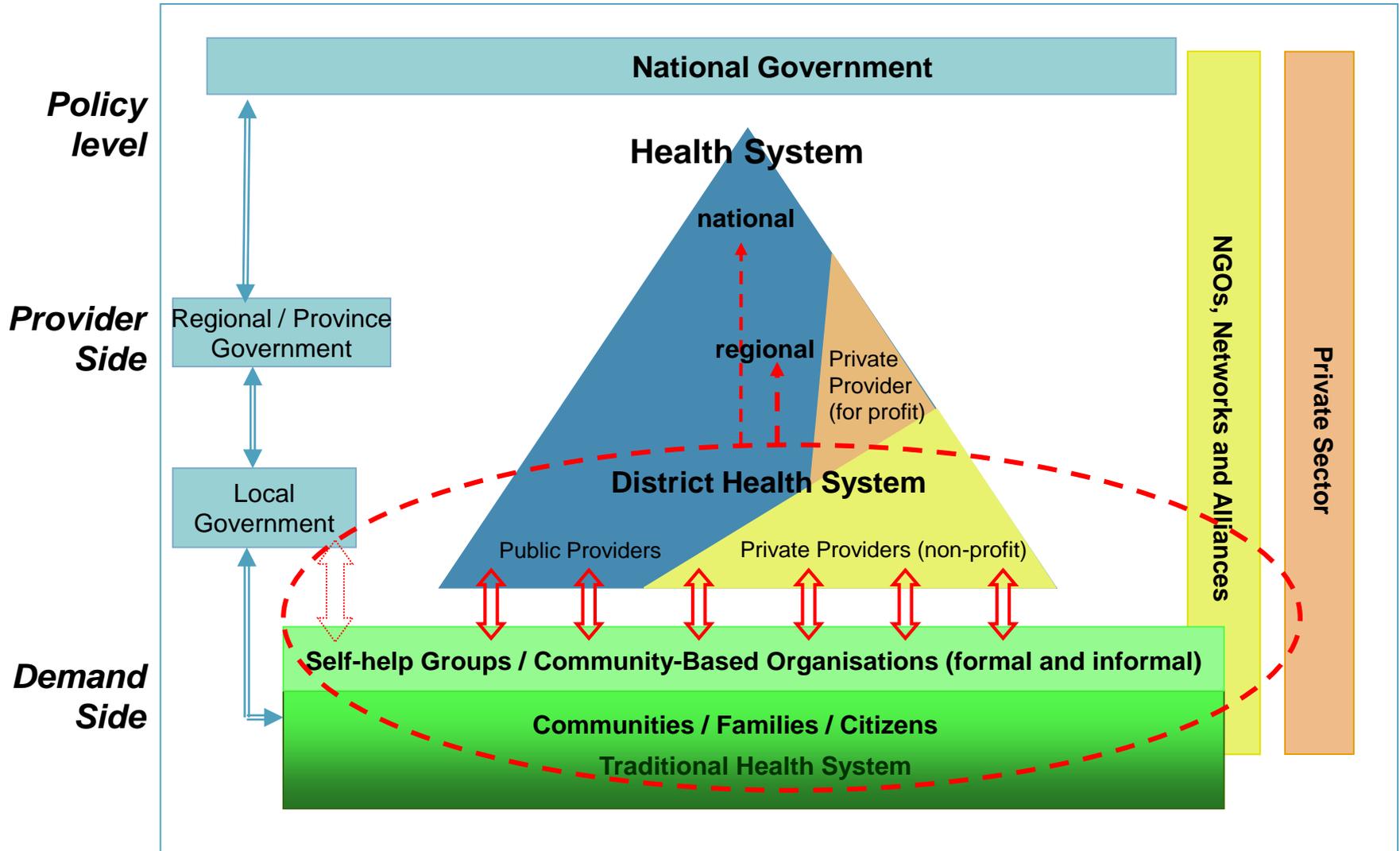
Questions:

- **Effects of the fragile context on the SRC programme**
- **Effect of SRC interventions on fragility**
- SRC Strategy of “staying engaged” in fragile contexts

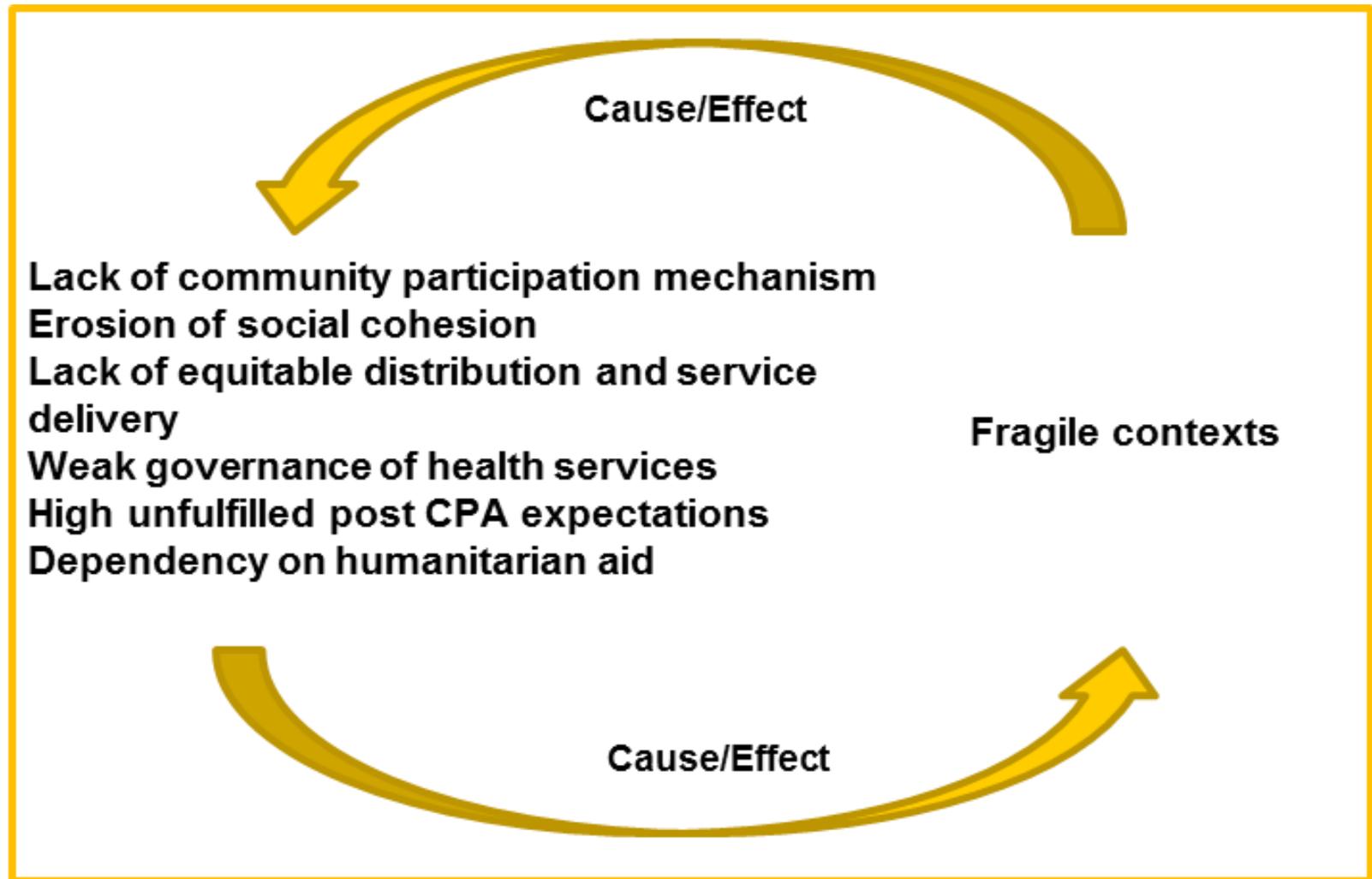
- Improve access to quality basic health care services (focus on women and children <5)
  - Constructed/equipped 6 health facilities
  - Provided community-based health service (95% coverage); integrated reference system
  - Capacity building: health staff /Red Cross branch staff
  - Community empowerment: Boma health committee/250 Red Cross volunteers
  - Decentralised bottom-up approach to handing-over strategy
  - Implementing partners: Sudanese/South Sudanese RC and Ministry of Health (2008 – 2013)
  - Full ownership by authorities and communities when conflict broke out 2013







Main focus of SRC  
Health programmes



**Key driver:** Lack of effective mechanisms to ensure inclusive participation and equitable distribution

**Requires:** Participatory bottom-up approach – long-term planning – vision for health and community system strengthening – using an integrated approach

- Several stakeholders involved – 95% coverage – access to health care close to people avoids risk taking for the population (women)
- Transparent process, consensus – all had the same information – coherence in approach even when authorities changed
- Fostered collaboration – tools for conflict solving – positively viewed and used by counterparts
- Trust relation – local counterparts ask for support
- Direct voice for Civil Society – communities motivated by responsibility and ownership, leading to action
- RC volunteers strong link between communities and health system – first source of information and action

- Long term vision and outcome difficult to predict in fragile context
- Time consuming process – non linear process needs flexibility
- Different groups have to be moderated – avoid dominance by one
- Pull effect from neighbouring county, which did not have services
- Changing authorities creates inertia (takes longer than planned)

**Key driver:** Erosion of social fabric, unaddressed traumas and mistrust

**Requires:** Improved interaction between communities and health staff

- Civil society helped to identify concerns and find solutions (e.g. security for women)
- Red Cross network/volunteers accessed first hand information; especially important during crisis
- No in-built strategy to address trauma of the population and staff

**Key driver:** Weak governance structure (rapid changes, no structure, corruption)

**Requires:** Strengthening local health structures and authorities at all levels

- MoH staff was part of the strengthening process
- Adhered to national policies and strategies
- Improved quality of service delivery – high community satisfaction
- Contributed to greater government legitimacy and acceptance
- Authorities accepted responsibility and accountability in the handing over process
  
- Tendency to bypass weak official structures and authorities
- Frequent changes of authorities and staff - time consuming and interrupts established processes
- No scaling up (one county covered)

**Key driver:** Weak governance structure (rapid changes, no structure, corruption)

**Requires:** Capacity building / on-the-job coaching for communities and MoH staff

- Knowledge / capacity remains with staff and communities – increased capacity and quality of service - on-the-job coaching very effective
- On-the-job coaching strengthens local capacity, especially in crisis – trust relation and context knowledge help
- Huge lack of qualified staff – competition between programmes – training takes time
- Often only used to run a project/programme rather than to develop the health or community system
- Tendency for outsiders to take over when crises arise

**Key driver:** Discrepancy between post CPA expectations and State delivery (promises and realities)

**Requires:** Development and provision of health infrastructure through MoH, facilitated by Red Cross

- Regular service and prevention offered throughout the whole county – high client satisfaction – population less sick and more knowledgeable
- Authorities gained legitimacy through handover approach
- Ownership changed over time
- Implementer takes over government responsibilities – communities see organisation as health care providers

**Key driver:** Increased dependency on humanitarian aid

**Requires:** Change from survival focus to development and system strengthening focus

- Through discussion and facilitation, communities and authorities became pro active
- Participatory approach changed ways of thinking and acting
- Change in focus takes a long time
- Nearly all health services provided by NGO – communities and authorities take it as normal
- Fragmentation due to several health care implementers – makes it difficult to strengthen systems
- Back to survival focus after the crisis (rather than development)

- Knowledge of context and understanding of stakeholder relationships; focus on equity and local demands
- Long-term commitment and vision with high flexibility (incl. budgets!) – needs regular assessments and adaptation; helps to weaken dividers – strengthen connectors
- Link community and system strengthening approaches; focus on equity
- Locally anchored partner organisations; strengthens ownership/fosters dialogue
- Effective coordination mechanisms to align efforts; linking local level to national processes
- Capacity building (incl. strengthening counterparts) to foster accountability and legitimacy of (health) authorities at all levels - crucial to run services
- Fragility-sensitive approach; promote social cohesion and self reliance, address trauma

- Is not sustainable if staying at community level: need for scaling-up and dialogue between stakeholders at different levels
- Is not sufficient for state- or peace building - beyond health programmes
- No chance when fragility turned into conflict - would be interesting to evaluate more in-depth

- Programme always has an impact (intended or unintended) on the context – balance interventions and employment
- Systems are interconnected dynamic and complex – implementation needs feasible, realistic and flexible solutions
- Work at all levels to improve health – bottom up approach gives you credibility among the population and authorities
- To have an impact at higher levels, think of scaling up (example to other countries)
- Put more efforts into preparedness and understanding coping mechanisms in case of conflict – do more in terms of psychosocial support
- Involving authorities, traditional chiefs, communities and staff gives a good base
- Coordinate efforts for preparedness at district or regional level (not only at organisational level) – denial that a crisis may arise leads to no action
- Difficult to have a coherent “fragility level” definition
- LRRD and flexibility in fragile context – do not undermine development processes
- SRC do no harm concept - no fragility framework used - work in or on fragility?

