

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

For: Delegation of the European Union to South Sudan, and the Ministry of Health –  
Government of the Republic of South Sudan  
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**FINAL REPORT ANNEX I: Gender and the health sector: key challenges in the  
context of conflict**

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## Gender and the health sector: key challenges in the context of conflict

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## 1. Overview

South Sudan's socio-economic, humanitarian and conflict situation impacts negatively on the health of women and children, and is clearly threatening to overturn some of the gains which had been made in terms of maternal and child health. Even prior to the conflict, 56% of the population did not have access to basic health services, with women (who form the majority of the population) disproportionately affected<sup>1,2</sup>. While the maternal mortality ratio was reported to have dropped to 789 per 100,000 live births,<sup>3</sup> it is not evident whether this figure is comparable with the earlier one or accurately represents the current situation after almost four years of violent conflict and accompanying major population displacement and economic crisis. Moreover, acute malnutrition remains a major public health emergency in South Sudan with a declaration of famine in parts of the country, with children and women particularly affected. Other health challenges which pose an increasing risk to women at the current time include sexual gender based violence, HIV/AIDS and tuberculosis, and conflict-related mental health problems and trauma. Women are, in general less educated than men, have lower access to services, and due to cultural reasons, may have constrained agency. It is often not the woman's prerogative to attend ANC services, use modern family planning methods, or practice safe sex. Alongside this South Sudan has, as elsewhere in Africa, an increasing disease burden in terms of non-communicable diseases, as well as ongoing endemic tropical diseases which have been eradicated in some other countries. Women and girls are the primary care givers, where services lack or are difficult to access the additional burden falls on them, impacting their ability to attend school to education, work, or receive care for their own needs.

The health system faces a range of challenges which impede the delivery of women's health services. These include limited health infrastructure, human resources for health, minimal government health care financing, weak management of the supply chain for pharmaceuticals and medical products, weak health information systems and poor coordination between multiple stakeholders. The value of the Ministry of Health's

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<sup>1</sup> South Sudan Household Health Survey (SSHHS) 2010

<sup>2</sup> Health Facility Assess Survey, 2012, Ministry of Health

<sup>3</sup> WHO/UNICEF/UNFPA/World Bank estimates, 2015

budget has, in line with GRSS expenditure as a whole, fallen by over 90% since 2014. This shortfall has not been made up by other actors.

All of the HPF donors have either statutory obligations or official policies committing them to addressing gender inequities and issues pertaining to the exclusion of women through their programming. The non-governmental organisations which act as implementing partners have similar charters which identify gender-related issues as a core component of their activities. The design of HPF2 incorporated an increased focus on gender-related issues, with specific activities related both to an expansion of female-specific services (including ANC, EmONC, GBV services) and broader social inclusion of women in decision-making structures.

The MOH has consistently emphasised gender in its policies and strategies. It has also developed a Gender Mainstreaming Strategy, the official launch date of which is due to be announced once the scheduled training for MoH staff and tutors on the use of the document is conducted in early October 2017<sup>4</sup>. A key channel for its implementation is through training of MOH staff and health training institute tutors, this will hopefully ensure that gender considerations are incorporated into core planning and service delivery. The impact of an increased focus on gender during training is limited by the small number of health workers graduating from the HTIs, the subsequent low absorption rate of these graduates into the workforce, minimal deployment of newly trained health workers to rural areas, and absence of routine in-service or refresher trainings for existing health workers.

Increasing attention has been paid to gender by both the government and partners in recent years. There have been improvements in the availability of services, and in the representation of women within community-level oversight bodies and committees. However, it is not yet evident that there has been substantive progress in planning, allocating resources, and mitigating the burdens women face. The ability of the MOH to effect improvements in gender related issues within the sector is unclear. In the context of overwhelming needs, limited funding, inadequate management structures, and severely limited access to many parts of South Sudan due to conflict and impassable roads, sustaining even rudimentary services is a huge challenge.

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<sup>4</sup> In draft form as of October 2017, expected to be published in its final form late 2017 or early 2018

## **2. Key challenges and opportunity areas**

### **2.1 Women and girls' sexual reproductive health and rights**

#### **Progress and achievements**

South Sudan was the 39<sup>th</sup> country to commit to FP 2020, to increase contraceptive prevalence rate (CPR) from 4.7 to 10%; a number of clinical officers have been trained to perform emergency obstetrics surgery (becoming 'associate clinicians', 120 health personnel have been trained in clinical management of rape; construction of infrastructure such as the Kiir Mayardit Women's Hospital in Rumbek, and upgrading of Primary Health Care Centres so that they can offer BEmONC or CEmONC services; Capacity building of young people developed to deliver SRH information services; 120 health personnel trained to deliver clinic management of rape; maternal death surveillance and response (MDSR) roadmap developed; Youth friendly services training package developed; comprehensive sexuality education (CSE) curriculum developed and teachers trained in collaboration with Ministry of Education; reproductive health (RH) and family planning (FP) policies developed and in use; South Sudan Nurses & Midwifery Association established; the Youth Peer Education Network (Y-PEER) in all the 10 former States; clinical management of rape (CMR) services available in over 90 facilities; Addressing sexual reproductive health (SRH) issues initially through Minimum Initial Service Package; but now moving to regular programming for humanitarian settings as well;

- Maternal mortality rate (MMR) dropped from 2054(2006) to 789/100,000 live births in 2015 (WHO/UNICEF/ UNFPA estimate).
- Infant and child mortality rates, declined from 102 to 75 and 135 to 105 per 1000 live births respectively
- Teenage pregnancy stands at 300/1000 births
- South Sudan commitment to FP 2020 to increase contraceptive prevalence rate (CPR) from 4.7 to 10% by 2020
- Infrastructure: 6 maternity complexes, 2 maternal waiting homes, post graduate fellowship awarded for study in Obstetric Gynaecologist (OB/GYN), 171 specialists currently being trained; associate clinicians being trained in emergency obstetrics care/ surgery
- EMMR survey ongoing;
- Establish National RH coordination mechanism, at State level and for humanitarian actors

## **Continuing challenges**

South Sudan has some of the worst maternal and child health indicators in the world. The contraceptive prevalence rate is 4.7%, almost one third of babies are born to teenage mothers, during the course of pregnancy less than half of women attend at least one ante-natal clinic consultation, and fewer than one in five attend the recommended minimum of four sessions. The limited availability of EmONC services contributes to a Caesarean-section rate of just 0.3% (compared with the WHO standard of 5-15%). Due to these, and other, factors, 789 women die in childbirth for every 100,000 live births and 3 in every 1000 suffer obstetric fistula.

Although illegal in South Sudan, 45% of girls are married before reaching age 18 – a situation that may be worsening because of the country's ongoing conflict. For many girls, this means uncompleted education, early motherhood, and worse health outcomes for themselves and their children<sup>5</sup>.

High rates of maternal and child morbidity and mortality point to failures in the health system, and stood out as a critical discussion point. Low service availability, low contraceptive prevalence, low facility-based deliveries, low coverage of safe deliveries by skilled attendants, limited youth-friendly health services, low child health coverage, limited skilled health workers, child marriage, high mortalities related to abortions, high teenage pregnancy and adolescent birth rates were among the challenges highlighted in the recent 3<sup>rd</sup> South Sudan Health Summit under the theme under the theme “Harnessing Strong Partnerships for a Resilient Health System towards attainment of Universal Health Coverage.”

Little attention is paid to the prevention of unwanted pregnancy as evidenced by low uptake of family planning services. Unsafe abortions account for 34% of maternal mortality. There is inadequate access for women, men and adolescents to comprehensive reproductive health information and to skilled care throughout the continuum of care for family planning, pregnancy, delivery, post-partum and post-natal periods.

## **2.2 Sexual and gender based violence**

Gender based violence is a threat to democracy, a burden on the national economy, an impediment to sustainable development and an appalling human rights violation.

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<sup>5</sup> <http://www.unfpa.org/news/i-decide-myself-south-sudanese-woman-shows-power-knowledge>

Sexual and gender based violence has long been endemic in South Sudan. It has been a hallmark of the conflict which has rocked the country since December 2013. There is limited protection from sexual and gender based violence. Survivors struggle to access care or achieve redress. Armed actors on all sides are able to commit sexual violence with impunity. Even in areas which are relatively peaceful, and nominally under the control of civilian authorities, negative attitudes from communities, police, and court officials deny justice to survivors. Domestic abuse is normalised and broadly accepted. Survivors who try to flee their abusers are typically pressured to return home, rather than break the marital contract under which a 'bride price' has been paid.

In conflict and post-conflict contexts, men and women experience violence differently. Women tend to experience violence in their homes, whereas for men it is outside the home<sup>6</sup>. New trends of violence emerged after the war<sup>7</sup>. Domestic violence is associated with the effects of war, militarization, polygamy and early marriage.<sup>8</sup>

The negative effects of the cultural, socialisation of the girl child and customary law together with high illiteracy among women of reproductive age contribute to child marriage and high incidences of gender based violence (GBV). MMR is high in South Sudan and a major contributor to this is abortion, which could be reduced by promoting Family Planning. About 34% of maternal deaths are due to abortions and, as such, it is important for the MoH to develop guidelines around this area. There are significant misconceptions around Family Planning, but research shows up to 30% of maternal deaths can be prevented by using birth spacing therefore, education around this is vital.

One of the most notable impacts of the continued sexual and gender based violence (SGBV) is the fear and paralysis it instils in the community. SGBV survivors are often in a state of permanent insecurity, and endure enormous stigma and are blamed for being assaulted<sup>9</sup>.

Although young girls and boys are subjected to violence and their naivety exploited, children, adolescents and adults with disabilities are three to four times more likely to

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<sup>6</sup> MoGCSW, Norwegian People's Aid, UNHCR, UNFPA, UN Women. Gender-Based Violence and Protection Concerns in South Sudan. P.31

<sup>7</sup> Ibid

<sup>8</sup> Ibid

<sup>9</sup> <http://www.unfpa.org/news/women-face-unspeakable-sexual-violence-south-sudan>

experience physical, sexual and emotional violence, and neglect than children without disabilities.

The conflict has created cultural pressures for women to reproduce lost members of the community. Many women are thus being forced to have more children although this may not be their choice and they may not be in a good condition to do so physically and/or mentally.

### **2.3 Human resources for health (HRH) and gender**

- The Ministry of Health has worked closely with Canada, and other donors supporting training of mid-level health cadres, to expand training opportunities for women. This has included preferential admission criteria (all women who achieve the necessary marks in entrance exams are admitted, then the remaining places are allocated to male students on the basis of their grades), and increasing the number of non-residential places so that women and girls can continue living at home while they study.
- MoH has sought to improve health workers' pay and conditions through harmonisation of salaries between government and NGO health workers, and regrading. Within the sector (and across the civil service as a whole) adherence to grading norms has historically been very weak. This manifests both in staff being employed under a lower grade (and therefore salary) than they ought to be, and unqualified individuals being given senior positions. The former practice disproportionately disadvantages women, the latter favours men. Strict enforcement of grading norms helps address this imbalance. Another component of the reforms was greater recognition for professional experience, specifically allowing community health workers and community midwives working in primary health clinics to progress to higher grades than was previously possible. Salary harmonisation was applied through the introduction of an 'infection allowance' for GRSS staff. This, combined with the 'promotion' meant that community health workers and community midwives received the largest proportional increase. Women are more heavily represented amongst these than any other skilled cadres.
- Contributing factors to the HRH challenges include: the lack of a national HRH retention policy; high staff turnover in government-managed health facilities; lack of financial resources for training output; and poor HRH management which is reflected in a lack of job descriptions, low and irregularly paid wages, and a lack of supervision at all levels .

- The conflict has had a particularly harsh impact on female health workers who are vulnerable to displacement and violence, including sexual violence.

## 2.4 Health financing and gender

- Funding gaps: the budget allocation as per Abuja target is recommended to be 15% of the national budget be allocated to health. This would imply, roughly, a quadrupling of which translates to \$34, of which \$6 per capita for RH, to be increased to \$8 per capita by 2015.
- Maternal mortality survey yet to be completed due to funding gaps and insecurities therefore there is no way to determine the accurate figure of MMR.
- Impact of the economic crisis on women's health services is devastating. Since the war broke out in December 2013, 106 health facilities have been closed, while many others have been looted or destroyed<sup>10</sup>. Women and young girls have been subjected to unimaginable level of cruelty, gender-based and sexual abuses. Access to quality healthcare is impeded due to numerous factors e.g. inaccessibility of health facilities as a result of the current and ongoing insecurity, lack of skilled health personnel, underdevelopment and low government commitment and expenditure to the health sector.

## 2.5 Health management systems and gender

- Women's role in health leadership and management at the various levels of the health system is poorly represented. Representation of women is far below the 25% figure as required under the constitution.
- Women's role in community participation, for example in management committees, needs to be promoted and women given training and support to fulfil their roles so that this representation is not merely tokenistic.
- The HMIS is not currently designed to adequately segregate data based on gender for analysis of gender related issues.
- Coordination: there is a need for stronger coordination with MoGCSW, as there is currently some confusion and gaps in terms of roles and responsibilities.

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<sup>10</sup> [http://ec.europa.eu/echo/files/aid/countries/factsheets/south-sudan\\_en.pdf](http://ec.europa.eu/echo/files/aid/countries/factsheets/south-sudan_en.pdf)

### **3. Recommendations / Way Forward**

There is great need to invest in a robust reproductive health services that are age appropriate and gender-sensitive. Gender equality is a critical social determinant, not only to address the social cultural issues that affect access to critical SRH services, but vital address various negative indicators suffering the Health care system in South Sudan.

Although Ministry of Gender Child and social welfare, is taking the lead with MoH and partners in developing a National Action Plan (NAP) to address child marriage, which is also contributing greatly to teenage pregnancy and maternal mortality in South Sudan, it is essential to create more awareness through the Boma Health Initiative / Boma Health Team (BHI / BHT) to sensitise people on Family Planning and deliver key messages by using terminologies that are understood by local communities using appropriate channels of communication for example posters are ineffective due to low literacy rates.

#### **National health policies**

- Create enabling environment by adopting and updating relevant policies, legislation, strategies and guidelines to facilitate gender sensitive and age appropriate access to SRH information and services.
- Efforts need to be made at all levels to ensure that gender and disability discrimination does not occur.
- MoH gender focal point to ensure gender is addressed across all directorates and services.

#### **Sexual and reproductive health services**

- Intensify and expand the coverage of SRH interventions with a concomitant preferential allocation of incremental resources towards these services.
- Develop a priority-oriented focus on RH service delivery, and ensure the best use of resources.
- Equip teaching and all State hospitals with the necessary capacity to provide advanced services and turn them into Centres of Excellence.
- Equip service delivery points with medicines and supplies for integrated SRH.
- Professionalise midwifery services to impact and reduce maternal mortality.
- Ensure SRH and gender equality are mainstreamed in the Boma Health Initiative. Create more awareness through the BHI / BHT to sensitise people on Family Planning and deliver key messages by using terminologies that are

understood by local communities using appropriate channels of communication for example posters are ineffective due to low literacy rates.

- Make use of the networks which exist in the education sector. Health workers could be posted to schools to collocate, making maximum usage of the limited number of permanent structures in many areas; female health workers, who might find it easier to work at schools, which are more firmly integrated with local communities than health facilities and tend to be located fairly centrally, would also have the added boon of increasing adolescent girls' access to services. The network for girls who receive cash transfers, and their closest female relatives, could provide a starting point for engaging with women.

### **Gender-sensitive health service delivery**

- Work to ensure all health facilities have latrines, soap, and water.
- Promote regular women-only clinics

### **Sexual and Gender-based Violence**

- Put in place policies, training and programmes to work towards the elimination of sexual and gender-based violence and to tackle its impact, through implementing a gender-sensitive protection and reporting mechanism, and through providing redress, rehabilitation services and access to justice for victims.
- Expand access to post-rape care (e.g. CMR services).
- Ensure that there is clear responsibility for SGBV policies and services within MoH at all levels.

### **Health management systems**

- Continue to build women's role in community participation and local management committees
- Empower women to assert their rights and demand accountability and coordination.
- HMIS – develop a clear mapping of inequities in access to services, including those which are gender-based.

### **Human Resources for Health**

- Building on the successes of the Rapid Results for Health Project in former Upper Nile and Jonglei, introduce small bonuses for staff working at facilities which hit

or exceed their targets for example, antenatal care and births attended by a qualified practitioner.

- The very low rates of education amongst women, cultural norms around women staying at home to look after their children and house, and the infeasibility of posting women to remote clinics in areas with which they are not familiar all create significant barriers to expanding the number of female health workers. To help mitigate some of these barriers:
  - Establish bridging or foundational courses which can teach women who did not finish school literacy and other things, so that they can then go on to train as health workers
  - Work with schools to publicise opportunities for entering health training institutes amongst girls who are nearing the end of their schooling
  - Introduce a cash transfers programme for female medical students, based on the GESS CTs

### **Health financing**

- Mandate minimum numbers of women on local committees/oversight boards which manage transfers.

## **Annex: List of Acronyms**

ANC	Antenatal Care
BHI	Boma Health Initiative
CMR	Clinical Management of Rape
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
EMMR	Expanded Maternal Mortality
FP	Family Planning
GBV	Gender Based Violence
MDSR	Maternal Death Surveillance and Response
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NAP	National Action Plan
OB/GYN	Obstetric Gynaecologist
RH	Reproductive Health
SGBV	Sexual Gender Based Violence
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation