2026:1g

Sida Evaluation

Impact study of the UNFPA Country Program for South Sudan

A case study as part of the Central Evaluation of Sida's work with Poverty Consultancy firm: Nordic Consulting Group A/S

Sida

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Abbreviations

DHIS	District Health Information System
ET	Evaluation Team
FCDO	Foreign Commonwealth & Development Office (UK)
FGD	Focus Group Discussions
FPET	Family Planning Estimation Tool
GBV	Gender Based Violence
HMIS	Health Management Information System
HRSS	Hope Restoration South Sudan
HPF	Health Pooled Fund
KII	Key Informant Interviews
mCPR	Modern Contraceptive Prevalence Rate
MDPA	Multi-Dimensional Poverty Analysis
MISP	Minimum Initial Service Package
NBS	National Bureau of Statistics
PPP	Purchasing Power Parity
SAADO	Smile Again Africa Development Organisation
SEK	Swedish Kroner
SGVB	Sexual and Gender Based Violence
SRH	Sexual & Reproductive Health
SRHR	Sexual & Reproductive Health Rights
ToC	Theory of Change
ToR	Terms of Reference
UNFPA	United Nations Population Fund
USD	United States Dollar
VAWG	Violence Against Women and Girls

Executive Summary

The Third UNFPA Country Programme for South Sudan (2019-2022) aimed to ensure universal access to sexual and reproductive health and rights, and to reduce maternal mortality in South Sudan. UNFPA adopted a systemic approach, partnering with the Government of South Sudan to strengthen national healthcare systems and deliver integrated sexual and reproductive health information and services. In parallel, it provided direct support to crisis-affected populations, particularly women and youth.

Our study shows that UNFPA has played a significant role in improving the availability, accessibility, and utilisation of services for sexual and reproductive health and gender-based violence in South Sudan. Concretely, UNFPA's support was critical to ensuring that over one million women and girls have had access to SRH and GBV services during the programme period, including in displacement-affected contexts.

Notably, the programme's focus on training and deployment of midwives led to increases in skilled birth attendance, which is directly linked to reduced maternal mortality. The programme also had a profound impact on mothers living with obstetric fistula who received successful treatment.

Nevertheless, our study also highlights the difficulty of achieving a long-term impact in such a fragile, conflict-affected context. Despite efforts to strengthen national systems for maternal health and family planning, achieving sustainable government ownership remains a significant challenge. The government lacks the institutional capacity, financial resources, and, most critically, the political commitment needed to maintain the services and systems established by the international community. As a result, the programme faced persistent challenges, including inadequate training for healthcare professionals, high staff turnover, delayed or unpaid salaries, and chronic shortages of essential medicines and medical equipment in health facilities.

1 Introduction

This report presents an impact evaluation of the contribution the "Third UNFPA Country Programme for South Sudan", covering the period 2019- 2022.[1] The case study constitutes a part of the overall "Strategic Evaluation of Sida's Work with Poverty".[2] It aims to contribute to learning and informed decision-making rather than control or accountability.

The Third UNFPA Country Programme for South Sudan aimed at addressing critical issues related to sexual and reproductive health and rights (SRHR), adolescents and youth, and gender equality in South Sudan. The evaluation is primarily a desk-based study.

The report is organised in the following way: In Chapter 2, the contribution case is presented and contextualised. Chapter 3 includes an outline of the main data sources and methods applied in the impact study. In Chapter 4, a reconstructed Theory of Change (ToC) for the contribution case is being presented and discussed. This is followed by a presentation of key impact findings in Chapter 5. Finally, in Chapter 6 the conclusions are presented.

Sida defines multidimensional poverty as deprivations within four dimensions - resources, opportunities and choice, power and voice and human security. Sida defines a person living in multidimensional poverty as being resource-poor and poor in one or several of the other dimensions.

Note that this definition is broader than the definition used in for instance OPHIs national multidimensional poverty index (MPI) and the World Bank definition of multi-dimensional poverty that uses the MPI in combination with monetary poverty.

Source: Sida (2019), Dimensions of Poverty, poverty toolbox.

[1] Originally, the programme covered 2019-2021 but was extended to 2022.

[2] There are seven other case studies, which are presented in separate reports.

2 The Contribution at a glance

Table 1. Overview of contribution

Contribution name	UNFPA 3rd Country Programme for South Sudan, 2019-2022
Partner	UNFPA
Implementing partners	UNFPA and other UN organisations under the 'Delivering as One' United Nations Cooperation Framework.
Implementation period	2019-2022
Sida strategy	Strategy for Sweden's development cooperation with South Sudan (2018-2022) as well as the Strategy for Sweden's cooperation with UNFPA (2017-2021)
Total budget	USD 55 million (UNFPA Country Programme Document)
Total Sida contribution	SEK 120 million (SEK 40 million annually), SEK 130 million (amendment no. 1 in 2020), SEK 190 million (amendment no. 2 along with a year extension to include 2022)
Other donor contributions	Funds were mobilised from: Canada, Sweden, Norway, Switzerland, Echo, Japan, Humanitarian Fund, UNFPA HQ and UN Joint initiatives.
Geographic coverage	All states of South Sudan

The United Nations Population Fund (UNFPA) Country Programme for South Sudan 2019-2022 was the third of its kind since the country achieved independence in 2011. The overall goal of the country programme was to enable universal access to sexual and reproductive health and reproductive rights (SRHR), as well as reduced maternal mortality in South Sudan. In collaboration with the Government of South Sudan, the country programme worked to strengthen national systems to provide integrated sexual and reproductive health information and services, while also directly delivering SRHR information and services to crisis-affected populations, women and youth.

Sida's contribution to the programme builds on longstanding collaboration between Sida and UNFPA, globally and in South Sudan. In particular, it builds on Swedish support to the Strengthening Midwifery Services project (2015-2017), which aimed at reducing infant and maternal mortality in South Sudan by improving availability and coverage of services.[3]

UNFPA's Country Programme applied a broader focus, working toward four main outcome areas:

[3] Sida (2019). Appraisal of Intervention: South Sudan UNFPA Country Program., p. 4

1. **Sexual and Reproductive Health and Rights**. Under Outcome 1, UNFPA aimed to enhance sexual and reproductive health and rights, particularly for women and adolescent girls in crisis-affected areas. It focused on expanding access to maternal health, family planning, gender-based violence (GBV) prevention, and HIV services through improved healthcare delivery, strengthened coordination, and capacity-building for health workers. In addition, UNFPA sought to strengthen national systems by investing in midwifery education, training maternal health providers, improving supply chains for reproductive health supplies, and conducting maternal death surveillance.[4]
2. **Adolescents and Youth**. Under Outcome 2, UNFPA has sought to improve sexual and reproductive health education and services among youth, and to increase youth participation in decision-making processes. The main strands of work have thus been to integrate comprehensive sexuality education into school curriculums and provide youth-friendly services, while supporting policy reform and advocating for young people's participation and influence in decision-making.[5]
3. **Gender Equality and Women's Empowerment**. Under Outcome 3, UNFPA's work has focused on strengthening multisectoral capacities to prevent and respond to GBV and harmful practices like child marriage. This has included advocacy efforts focus on engaging political, traditional, and religious leaders to change societal norms.[6]
4. **Population Dynamics**. Under Outcome 4, UNFPA focused on enhancing national systems to collect and use population data for planning and development. More specifically, this has included capacity-building for the National Bureau of Statistics and demographic research.[7]

The UNFPA County Programme worked across all states of South Sudan (as indicated in Figure 1); however, as illustrated below, not all of the services were available in all states (e.g., no UN Volunteer midwives were deployed in Jonglei).

[4] UNFPA (2018). Country Programme Document for South Sudan. p. 3
[5] Ibid, p. 4
[6] Ibid, p. 4
[7] Ibid, p. 5

Figure 1. UNFPA intervention areas

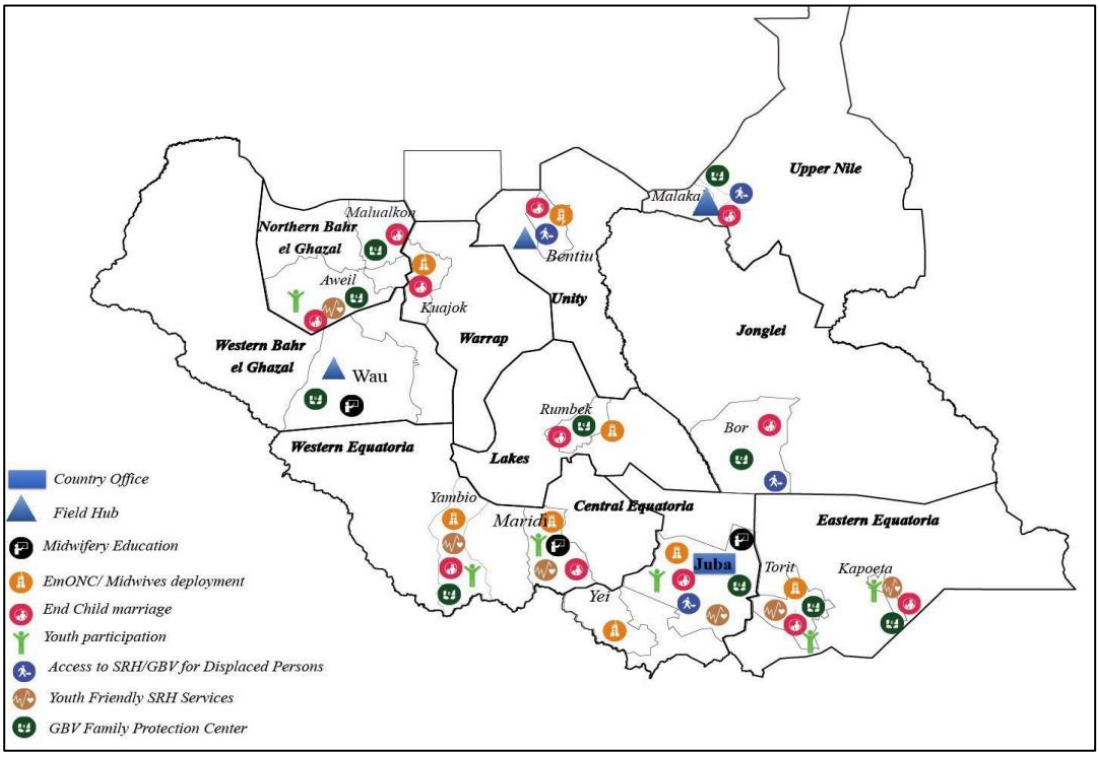

Figure source: Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). Evaluation of the Government of South Sudan/UNFPA 3rd Country Programme (2019-2021): Final Report.

2.1 THE PROJECT CONTEXT

Since gaining independence in 2011, South Sudan has faced continuous conflicts, significantly affecting its population and health infrastructure. In 2016, the majority of the population lived under the poverty line of USD 1.90 a day (2011 PPP), making South Sudan one of the poorest countries in the world.[8] The effects of South Sudan's protracted conflict - both before and after it gained independence in 2011 – is seen in terms of the massive erosion of physical and social infrastructure in the country, as well as the displacement of millions of people. This has resulted in overcrowded refugee camps both within South Sudan and in neighbouring countries lacking adequate sanitation, healthcare, and food supplies, and leading to deteriorating health conditions among the displaced populations.[9] Humanitarian needs in South Sudan are widespread and have grown significantly since independence, with underdevelopment of all sectors. South Sudan's rural population, as well as women and youth, are particularly vulnerable, as is highlighted in Sida's Multi-Dimensional Poverty Analysis (MDPA).

[8] World Bank (2024). Poverty and Inequality Platform (version 20240627_2017_01_02_PROD) [data set].pip.worldbank.org. Accessed on 1 November 2024. Available at: https://pip.worldbank.org/country-profiles/SSD

[9] Kajue, I., Ndizi, J., Wekesa, E., and P. N. Fonkwo. (2015) Comprehensive Midterm Review of the First UNFPA Country Program of Assistance to the Republic of South Sudan(2012-2016): Final Report, p. 4.

South Sudan has some of the worst health indicators in the world, especially on SRHR. The situation is particularly dire when it comes to maternal mortality – the WHO World Health Statistics estimate for 2020 indicates a maternal mortality rate of 1223 per 100,000 live births – the highest in the world.[10] Neonatal mortality and under-five mortality rates are likewise alarmingly high, respectively 40 and 99 per 1000 live births in 2021.[11]

Adolescent and/or child marriage is widespread, with teenage pregnancy estimated at 30 percent among 15–19-year-olds.[12] In fact, a UN report from 2016 highlighted that girls in South Sudan are three times more likely to died due to childbirth than complete a primary education.[13] Obstetric fistula[14] prevalence is estimated at 3% of women in the reproductive age group, with a particularly high caseload among teenage pregnancies (300/1000 teenage pregnancies).[15]

Family planning needs are largely unmet in South Sudan, with an estimated 96% of women between aged 15-49 years currently married or in union and unable to access modern family planning methods.[16] Estimates indicate that a marginal increase has happened over the last decade in the use of modern contraceptive methods, from 3.3% in 2012 to 4.2% in 2023.[17] Nevertheless, unmet need for contraception was estimated to be around 30% in 2020.[18]

Owing to low contraceptive use and availability, sexually transmitted infections are a major concern in South Sudan. The HIV prevalence rate is estimated to be 1.6% among 15-49-year-olds.[19] Female sex workers are particularly vulnerable, with an HIV prevalence rate of 16%.[20] UNAIDS estimates that there are 130,000 orphans due to AIDS in South Sudan, between the ages of 0 and 17.[21]

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[10] WHO. (2023). The Global Health Observatory – World Health Statistics. Annex 1 – Country, area, WHO and global health statistics (of the World Health Statistics 2023).

[11] Ibid.

[12] UNFPA. (2021). Investment Cases Towards Ending Unmet Need for Family Planning, Preventable Maternal Deaths, and Gender-based Violence: South Sudan Synthesis Report. p. 2.

[13] UN OCHA. (2016). South Sudan Humanitarian Needs Overview.

[14] Obstetric Fistula is a medical condition whereby there is an opening between the vaginal wall and the urinary bladder, urethra, or rectum of a woman that results in leakage of urine and or faeces through the vagina. Teenage/adolescent mothers are particularly at risk. By prevention of Obstetric Fistula, the ET means targeted efforts in terms of family planning/contraceptive services, skilled birth attendance, and efforts to combat child/adolescent marriage.

[15] UNFPA, (2022). Press release: UNFPA, AMREF and Government launch an in-country standard training of fistula. Accessed on July 20, 2024.

[16] UNFPA, (2021).

[17] Track 20. (2023). South Sudan Family Planning Indicator Sheet: 2023 Measurement Report.

[18] UNFPA, (2021).

[19] UNAIDS. (2023). South Sudan Factsheet for 2023. Accessed at: https://www.unaids.org/en/regionscountries/countries/southsudan

[20] Ibid.

[21] Ibid.

The impact of the conflict on women and girls has been particularly devastating. Gender-based violence (GBV) has surged during the conflict, with many women and girls subjected to rape, forced marriages, and other forms of abuse. For instance, in 2017, a study reported that 65% of women have experienced GBV.[22]

In response to the above, the health and population and reproductive health sectors are the most prioritized among international partners in South Sudan (see Figure 2 below).

Figure 2 Annual Aid Flows to South Sudan by Sector

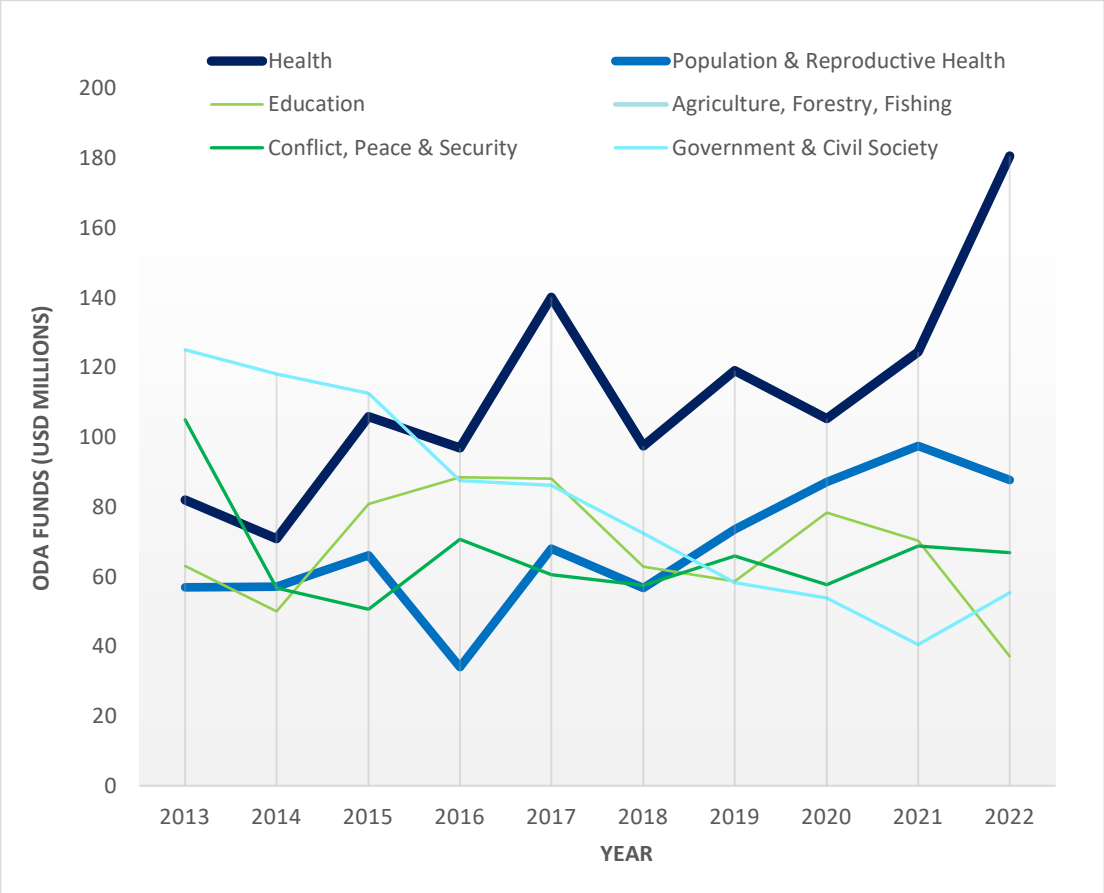

Chart notes: Based on ODA reporting from all DAC countries, total gross disbursements, combined unit of measure is USD Millions, 2021.
Source: OECD DAC. (2024). OECD.Stat: Creditor Reporting System (flows). Official Development Assistance (gross disbursements) to South Sudan by sector. Accessed on 12 March 2024.

[22] UNFPA (2018). Country Programme Document for South Sudan.

3 Data and methods

3.1 OVERALL APPROACH

The aim of the case studies has been to assess the impact of Sida's contributions on poverty, in line with the overall objective of Swedish development cooperation, namely, *to create preconditions for better living conditions for people living in poverty and under oppression.* For this case, the aim is thus to assess the degree to which UNFPA's country programme has contributed to higher level outcomes or an impact that benefits people living in poverty in South Sudan.

We used a mixed method, theory-based approach, reconstructing the programme's theory of change to assess the causal chain of the intervention to understand *how* and *why* an impact has been achieved (or not). The assessment also considers the underlying assumptions of UNFPA's theory of change, and whether these have held in practice or not.

The case study primarily draws on secondary sources, through a review of existing evaluation evidence, routine monitoring data and reporting by UNFPA, and external sources, such as research and national statistics. These external sources, i.e., research and indicators on family planning, SRHR and SGBV, have been used to validate the theory of change, i.e., the types of effects that might be expected from UNFPA's interventions, to support contribution analysis.

In addition, secondary sources have been supplemented with a number of interviews conducted by the evaluation team of UNFPA staff, implementing partners, and other donors working in the health/SRHR sector when the team undertook a field visit to Juba in February 2024.

The following sections elaborate on data availability, reliability and credibility, and the limitations of the case study and its findings.

3.2 DATA AVAILABILITY

Data availability is a major challenge in the South Sudan context in general, including when it comes to healthcare, health outcomes, family planning, and SRH more broadly. Open Data Watch, an international non-profit that provides in-depth country-level assessment of data coverage and openness ranks South Sudan 193rd out of 195 countries and territories. In terms of data coverage – i.e., availability of national and subnational data on population dynamics, health, education, food security etc. – South Sudan scored

3 out of 100.[23] Data availability challenges in South Sudan, owing to the fragility and complexity of the context, as well as weak statistical capacity and limited resources for data collection at national level, result in data gaps across key SRH indicators, outdated data, and/or estimates. For example, no recent national data is available on maternal mortality,[24] and therefore donors and policy makers to a large degree rely upon outdated national datasets, estimates, or limited sub-national or project monitoring data.

While Health Management Information System (HMIS) data increasingly has become available as more health facilities have begun to report through the District Health Information System (DHIS) 2 – an increase that in a large part stem from donor investment in the sector and pressure on facilities to collect and share data –significant challenges remain with data quality, hereunder timeliness, completeness and accuracy, including on maternal health and SRH.[25]

Thus, while we draw on national and sub-national data collected by the Government of South Sudan or other UN agencies, we also relied significantly on UNFPA's own data and monitoring of the programme. UNFPA's annual reports from each implementation year provides data on achievements and progress towards output indicators. In addition, an independent endline evaluation (referred to throughout this case as the "Country Programme Evaluation) was undertaken, applying a mixed-methods approach including document reviews, interviews, group discussions and observations during field visits.[26]

3.3 DATA RELIABILITY AND CREDIBILITY

As described above, a variety of secondary sources of information are drawn on in the case study, supplemented by primary data collected through interviews. These will be discussed in further detail below.

3.3.1 The Country Programme Evaluation (2021)

A key source is the above-mentioned Country Programme Evaluation undertaken by a team of external and independent consultants. The reliability and credibility of the Country Programme Evaluation is unfolded in Table 1 below.

[23] Open Data Watch. (2023). Open Data Inventory: Country Profile South Sudan. Accessed at: https://odin.opendatawatch.com/Report/countryProfileUpdated/SSD?year=2022

[24] UNFPA. (2015). Summative Evaluation of the Strengthening Midwifery Services Project in South Sudan, p. 20.

[25] World Bank Group. (2021). Health Service Monitoring in South Sudan. Policy Brief 2/5.

[26] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). Evaluation of the Government of South Sudan/UNFPA 3rd Country Programme (2019-2021): Final Report., p. 15-16.

Tabel 2. Assessment of the reliability and credibility of the main impact evaluation data source.

Criteria	Evaluation of the Government of South Sudan/ UNFA 3rd Country Programme (2019-2021)
Usability	Provides an overview of achievements of the Third UNFA Country Programme in South Sudan.
Credibility	The Country Programme Evaluation was undertaken by an external and independent evaluation team. It draws on routine monitoring data provided by UNFPA as well as national statistics, where other data sources are available. It also involved significant primary qualitative data collection – including at beneficiary level – through key informant interviews and focus groups as a way to validate and elaborate on findings from secondary data collected.
Results level	Output and outcome level, however there are significant gaps in the outcome-level data, due to data availability issues. In addition, the Country Programme Evaluation does not address impact as an evaluation criterion, nor has UNFPA included any evaluation questions that directly address the programme's impact. Therefore, it primarily provides basis to assess effectiveness against higher-level outcomes.
Data quality	The Country Programme Evaluation draws significantly on UNFPA's own reporting. UNFPA program data for key SRH/GBV indicators is derived from the National Health Information Management Systems, as well as the GBV information management system. It is difficult to ascertain the quality of primary data collected by the evaluation (interviews, focus groups), as these primary data sources are not available, but are referred to- and the basis of the meta-analysis.
Quantitative and/or qualitative evidence	The Country Programme Evaluation applied a mixed methods design, drawing on both quantitative and qualitative methods. Primary data collection was predominantly qualitative, drawing on structured and semi-structured key informant interviews (KII) and focus group discussions (FGD) with key project stakeholders. A total of 129 interviews were conducted, the majority of which (58%) were with beneficiaries of the project, with more emphasis on women in line with the project focus. In addition, the Country Programme Evaluation drew on several secondary qualitative and quantitative data sources, including document review of all programme and progress reports, budget and programme expenditure data, as well as triangulation of output/outcome data with national statistics.
Reliability	The Country Programme Evaluation was undertaken during the COVID-19 pandemic, which limited the team's ability to travel, meet stakeholders face-to-face, and visit service delivery sites. To a certain extent, this limits reliability of certain findings, where the team has had to rely more on secondary and remote data collection.
Conclusion	Sufficient confidence. The Country Programme Evaluation is credible and reliable enough to draw on for the analysis, with the caveat that there is an apparent gap in the data with no explicit impact-level analysis.

High confidence	Sufficient confidence	Limited confidence	Insufficient evidence
Based on usability, addresses impact level, identified bias mitigated, good data quality	Confidence reduced by shortcomings to usability, indications of bias not mitigated, less convincing data quality	Low confidence due to lack of usability, clear bias not mitigated, poor data quality	Insufficient evidence to support a contribution judgement

3.3.2 UNFPA's routine monitoring data

As noted above, we also draw on UNFPA's routine monitoring data. UNFPA has conducted timebound data collection and provided data at output level in the annual progress reports. UNFPA's data for key SRH/GBV indicators is derived from the National Health Information Management Systems as well as the GBV information management system.

3.3.3 National statistics

We also drew on national statistics to triangulate and validate findings from the Country Programme Evaluation and UNFPA's routine monitoring data. As was noted above in Section 2.1 national and subnational data on health and SRH in South Sudan is not collected regularly nor systematically; thus, measurement of certain indicators relies on outdated data, estimates, or extrapolation based on comparison across different surveys.

3.3.4 Research

We also drew on external research and evidence to assess the validity and plausibility of the UNFPA's theory of change, and its underlying assumptions. These also provided external sources of data on health indicators, such as maternal mortality, contraceptive prevalence rates, SGBV and other, which were drawn on in the analysis to further validate the data from the Country Programme Evaluation and UNFPA.

3.3.5 Interviews UNFPA and implementing partners' staff in Juba

During our visit to Juba in February 2024, we interviewed three members of UNFPA staff in Juba, staff at the Ministry of Health, and staff at three implementing partner organisations (Hope Restoration South Sudan; AMREF; and Smile Again Africa Development Organisation). These interviews were used to validate other data sources – particularly the Country Programme Evaluation and the routine monitoring data – however no facility-level/field visits were conducted to verify information firsthand.

3.4 LIMITATIONS

The limitations of the case study in terms of data availability, credibility and quality have more or less been covered above. The ET is limited by the same factors as UNFPA and other development actors engaging in South Sudan: a lack of recent and high-quality data across most of the SDG indicators.

In terms of drawing on UNFPA's monitoring data (which is a key secondary source of data for the Country Programme Evaluation), it should be noted that UNFPA does not explicitly define impact-level ambitions nor indicators, at the country level. For this reason, UNFPA's monitoring data only lends itself to analysis of attainment of higher-level outcomes.

While the Country Programme Evaluation intended to apply a theory-based approach, the assessment of the intervention logic, assumptions and causal mechanisms in the ToC was given limited attention in the report. We have therefore dedicated extra attention to the ToC and underlying assumptions in the following chapter (Section 3.1).

4 Theory of Change and Sida's Poverty Dimensions

4.1 ASSESSING THE THEORY OF CHANGE

UNFPA has developed a separate theory of change (ToC) for each of the four outcome areas of the country programme (2019-2021), which we have consolidated into one overarching ToC for the programme (see Figure 2).

It is worth noting that not all outcome areas are weighted equally in the programme. The first outcome, Sexual and Reproductive Health, is the primary focus on the programme, receiving 78% of the total budget,[27] and cuts across the other outcome areas (youth, gender equality, and population dynamics). For this reason, we will largely focus on the first outcome in the analysis below.

Across each of the outcomes, UNFPA has five so-called "Modes of Engagement" or approaches (included as "drivers/approaches" in the ToC model below), which are i) advocacy and policy dialogue; ii) knowledge generation and sharing; iii) capacity-building, iv) partnerships and coordination, and v) service delivery.

In general, these approaches ensure that UNFPA *in theory* takes a holistic approach to attaining each outcome area, i.e., addressing structural barriers related to the policy framework, ensuring that SRH/family planning services are available, and that data is generated to allow for evidence-based policymaking and programming, and partners have adequate capacity and capitalize on synergies.

In practice, it has been difficult for us to ascertain whether all five "Modes of Engagement" have contributed to UNFPA's intended impact/higher-level outcomes, in part owing to a lack of data/information or poor indicators e.g., to assess the efficacy of capacity development of partners; coordination with other actors; and even policy dialogue/ advocacy efforts. For example, UNFPA has included indicators, e.g. to measure whether a coordination forum has been established and is functional, but this does not signal whether coordination has had an effect on achievement of outcomes.[28] On the other hand, on service delivery, the data is more readily attainable (at output level) and therefore gives a clearer indication of results achievement.

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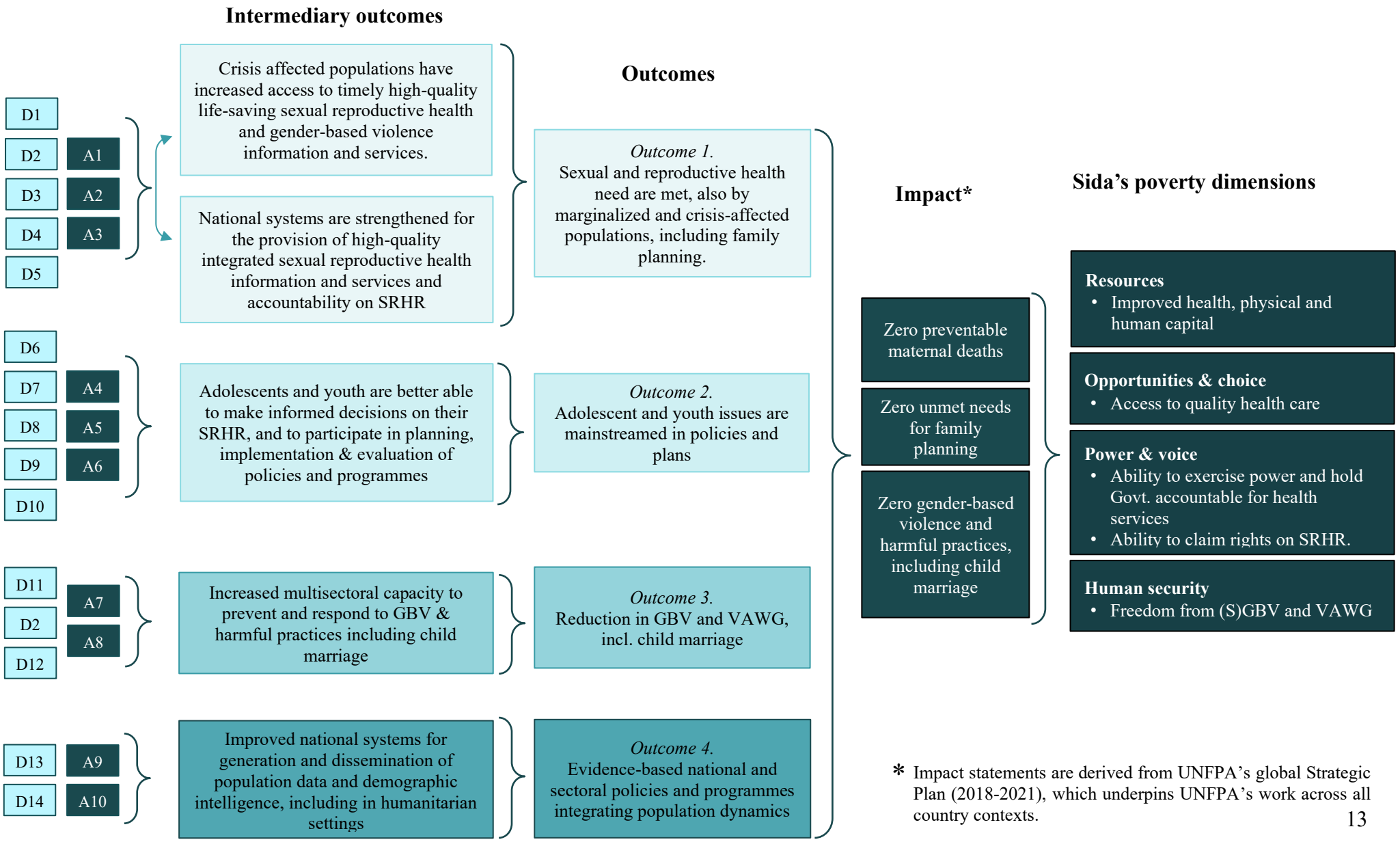
[27] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). Evaluation of the Government of South Sudan/UNFPA 3rd Country Programme (2019-2021): Final Report., p. 29.

[28] The country programme evaluation arrived at a similar conclusion with regard to certain indicators, stating that "*some output indicators were stated as categorical; requiring only "Yes" or "No" as the only options for measuring achievement. These categorical measurements fell short of clearly defining the quality, processes and parameters of measurement."* P. 36.

Figure 2. 3rd UNFPA Country Programme - Theory of Change (including assumptions and drivers, found on the following page)



* Impact statements are derived from UNFPA's global Strategic Plan (2018-2021), which underpins UNFPA's work across all country contexts.

Assumptions

A1: Improved economic conditions resulting into reduced costs of doing business and government ensures trained health personnel are recruited, deployed and retained in the public health sector

A2: The humanitarian situation does not deteriorate further, and ongoing peace efforts are embraced by the various warrying actors and most service outlets are re-established

A3: Donor allocation of resources to SRH and GBV in emergencies continues to improve.

A4: Economic condition allows for conducive environment for investment in youth and adolescents and for access to basic services

A5: Parliament and judiciary are supportive in approving youth bill and policies

A6: Religious and cultural leaders are supportive of comprehensive sexuality education for young people.

A7: Political will Ministry of Gender and Health to support gender integration efforts on gender-related issues.

A8: Communities are willing to change social norms that contribute to gender inequality, GBV, and VAWG (incl. child marriage).

A9: Stability and peace from conflict provides conducive environment for data collection to take place on population dynamics

A10: Economic situation allows for allocation of sufficient resources to finance data collection activities

Drivers (approaches)

D1: Advocacy and policy dialogue through SRHR leadership advocacy, strengthening the national midwifery and nursing association and advocacy with Humanitarian Country Team to address GBV and VAWG.

D2: Knowledge generation and sharing by social and behaviour change communication, facilitate research to inform gender sensitive programmes and strengthening GBV information management

D3: Capacity-building in health facilities to provide emergency obstetric and newborn care services and scaling up availability of qualified health personnel among others

D4: Service delivery of RH and GBV services, provision of youth friendly services in prevention of STDs, deployment of UNV midwives and social and behaviour change communication.

D5: Partnerships and coordination through facilitation of joint programmes to scale up maternal health services, and strengthen GBV and RGH working groups at national and sub-national level among others

D6: Policy advocacy to mainstream youth issues

D7: Review of National Youth Bill and Youth Policy

D8: Youth assessment and mapping of youth-led and youth-serving organisations in South Sudan

D9: Capacity development of youth to strengthen awareness on SRHR, advocacy, and leadership.

D10: Partnerships and coalition-building with youth-focused organisations

D11: Advocacy and policy dialogue on GBV, VAWG, and child marriage.

D12:Coordination with health sector and gender technical working group, and support to implementation of national strategies to end child marriage & GBV

D13: Advocacy and policy dialogue in support of policy-oriented research on population and demographics.

D14: Capacity development of National Bureau of Statistics

The Country Programme Evaluation provided some analysis of UNFPA's ToC and broadly concluded that it was "generally based on a sounder intervention logic that the strategic four outcomes and the five outputs are contributing to the attainment of the outcomes". This conclusion is largely in line with our own assessment of the ToC, although, given the very broad (or holistic) approach taken by UNFPA, some of the 'nitty gritty' details linking specific strategic interventions or activities to the outcomes are missing or left implicit.

The same can be said in relation to risks and assumptions. While UNFPA's theory of change includes a section on risks/assumptions that underpin the expected results, these are few, and on a very general level, given the wide array of intervention areas and types. These risks/assumptions (which are included in the blue box in Figure 2) cover a range of different aspects, from the macro-economic situation, government engagement, and community buy-in. Our assessment of the degree to which a number of key assumptions have held up is elaborated on in Table 3 below.

Table 2. Assessment of the Country Programme's underlying assumptions

Assumptions	Assessment	Sources
A1, A5 & A7. Government support, political will and buy-in to make policy-level changes, support gender integration, train, recruit and deploy health personnel & prioritise funding to SRH and data collection on population dynamics.	**Appears to partially have held up**. On paper, UNFPA is aligned with the Government of South Sudan. However, government support or alignment is not always a guarantee that intended changes come about. For example, under outcome 1, one of the defined assumptions is that the "*Government ensures trained health personnel are recruited, deployed and retained in the health sector*".[29] In practice, this has proven difficult; in fact, the inability of the Government to deploy and retain health workers such as nurses, midwifes and associate clinicians was a key barrier for progress on delivery of SRHR services. [30]	***Primary data:*** • Interviews with UNFPA staff; • Interviews with FCDO (as part of Health Pooled Fund case) ***Secondary data:*** • Country Programme Evaluation
A6. Community acceptance and engagement, including religious and cultural leaders support for comprehensive sexuality education for	**Limited evidence but appears to partially have held up**. Several of the respondents from UNFPA's implementing partners (IPs), highlighted this as a challenge, particularly at the outset ("*there was not a very warm reception from community leaders"*). However, some claimed that the interaction has become 'easier' with time, e.g., in Unity State, where all 7 counties have supported a bylaw to end child marriage with support from traditional leaders. Community	***Primary data:*** • Interviews with UNFPA's IPs. ***Secondary data:*** • Country Programme Evaluation

[29] UNFPA,(N.D.), Country Programme Outcome -Theory of Change on Sexual and Reproductive Health and Rights. p.1.

[30] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 60.

youth, and promotion of social norms that oppose GBV, VAWG, child marriage, etc.	acceptance is not explicitly covered in the Country Programme Evaluation, leaving us with primarily anecdotal evidence.	• UNFPA South Sudan Annual Report 2022
A9. Stable security conditions that allow implementing partners access to communities/health facilities, allows for data collection and monitoring activities; reduction in insecurity also indirectly reduces SGBV/VAWG.	**Assumption partially held up - but where it did not hold up, it has significant implications on the intervention's impact.** The Country Programme Evaluation concluded (in relation to the programme's coverage) that "when new emergencies arise […], due to prevailing insecurity and a bad road network, programme interventions tend [to be] concentrated in areas where there is access and improved security".[31] Other development actors have had similar challenges (e.g., see also Health Pooled Fund (HPF) case study) with outbreak of conflict in specific localities leading to a pause in health service provision.	***Secondary data:*** • Country Programme Evaluation
A1, A4 & A10. Economic situation in South Sudan is conducive to finance data collection activities from national budget, and to increase investment in youth and adolescents' access to basic SRH services.	**Evidence largely points to the contrary.** Based on discussions with donors in Juba and the Ministry of Health (MoH), it is clear that MoH is significantly underfunded; in 2017/18, only 2.2% of the national budget was allocated to health, and actual spending even lower. Likewise, in 2022/23, MoH allocated only 2.41% of national annual budget or $77m, but spent only 13% of this allocation, or $10m.[32] Inadequate funding from government has led to limited implementation coverage on maternal health services and has likewise impeded data collection on population dynamics.[33]	***Primary data:*** • Interviews with UNFPA staff. • Interview with FCDO staff. • Interview with a MOH official. ***Secondary data:*** • Country Programme Evaluation
A3. Donor allocation of resources to SRH and GBV increases or improves.	**This assumption has held up** according to OECD/DAC data (see Figure 2 above) on aid flows. However, the assumption is not linked in any way to UNFPA's programme and/or outcomes in the ToC, making it unclear how it impedes or supports results attainment. Notably the OECD/DAC data indicates that support to population and reproductive health decreased from 2021 to 2022, directly after the end of the Country Programme. This may affect the sustainability of activities implemented by the Country Programme.	***Secondary data:*** • OECD DAC Dataset, Aid Flows

[31] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 57.

[32] Figures for MoH budget allocations and actual expenditure are based on FCDO's reports to the ET.

[33] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 41; p. 49.

4.2 LINKS TO SIDA'S POVERTY DIMENSIONS

Since the country programme includes no impact statement, the assumptions and causal link between the outcomes and wider impact on peoples' lives is (understandably) not captured in the ToC. Nevertheless, UNFPA's intervention areas – particularly when it comes to improving SRH services and reducing (S)GBV – have very tangible impacts on the lives of people living in poverty, as will be evidenced in Chapter 5.

The programme cuts across all of Sida's dimensions of poverty, but in particular contributes directly to addressing poverty in terms of opportunities and choice, human security and to the (non-material) resource dimensions. Given the broadness of the UNFPA country programme, the impact analysis focuses on the main achievements related to the four outcome areas.

5 Findings on impact

5.1 ASSESSING THE CONTRIBUTION'S IMPACT ALONG THE FOUR OUTCOME AREAS

Outcome Area 1. Sexual and Reproductive Health

The programme has contributed to improved access to SRHR services, including family planning. These are important factors for in fostering an enabling environment for gender equality and have a direct impact on health and even mortality (*resources; opportunities and choice*). See table 4 below with achievements against key indicators from the 2021 Country Programme Evaluation):

- ***Contraceptive use & availability.*** UNFPA's indicator – measuring the modern contraceptive prevalence rate (mCPR) in the population in the districts where UNFPA works – indicates an increase in the use of contraceptives by 2 percentage points by 2020, which is significant since the starting point was a mere 1.2% (2019). FP2030's Family Planning Estimation Tool (FPET) figures for 2021, 2022, and 2023 indicate a continuous upward trend, with an mCPR of 4.2% in 2023.[34] Nevertheless, the same dataset indicates that unmet needs for modern methods of contraception have remained high over the period (22.8% in 2019; and 22.7% in 2021), signalling that there still is a long way to go.[35]

  In terms of access and availability of family planning methods, UNFPA has been the sole provider of reproductive health commodities to public health facilities in South Sudan according to the Country Programme Evaluation. Thus, it is noteworthy that the percentage of clinics/"service delivery points" that have faced stock-outs of at least 3 common contraceptive methods has reduced. At the baseline (2019) 69% faced stockout, which was reduced to 33% in 2020 when the endline evaluation was undertaken.[36] While this indicator signals improvement on the supply-side, it is not able to capture whether demand for family planning/ modern contraceptives has grown.

[34] Family Planning 2030. (2023). FP2030 Indicator Summary Sheet: 2023 Measurement Report for South Sudan. Accessed at: https://wordpress.fp2030.org/wp-content/uploads/2023/04/South20Sudan20202320Indicator20Summary20Sheet1.pdf

[35] Family Planning 2030, (2023). Indicator Summary Sheet: 2023 Measurement Report for South Sudan.

[36] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 38.

- ***Presence of skilled birth attendants***. The Country Programme Evaluation highlights that the proportion of births attended by skilled health personnel has increased significantly from the baseline to the time of evaluation, particularly felt in the facilities targeted by UNFPA, where 79% of deliveries were overseen by skilled health personnel.[37] The positive trend was also noted by the Health Pooled Fund (HPF), which reported that in 2022, 25.7% of all births were delivered in a health facility in the presence of skilled personnel.

  UNFPA and HPF are reportedly some of the biggest actors engaging on maternal mortality and SRH, but nonetheless, these changes must be seen in light of the bigger picture, where other actors may have contributed. We note that UNFPA has had a particularly instrumental role in terms of addressing the supply side, namely through the education and training of nurses and midwives. When the Country Programme Evaluation was undertaken, UNFPA had trained an additional 218 midwives. Nevertheless, the evaluation concluded that the number of midwives produced remains low when compared to the huge demand, reiterating the challenges discussed above with the deployment and retention of skilled healthcare staff.[38]

- ***Obstetric fistula.*** While UNFPA has focused on prevention of obstetric fistula – one of the most serious childbirth-related injuries – the organisation has also through the country programme supported fistula repair surgery. In 2022, UNFPA (in a press release) reported approximately 60,000 backlogs of women living with Obstetric Fistula in South Sudan, whereof just under 1000 had received surgical repair and treatment (baseline in 2019 was 900 patients).[39] Through the country programme, UNFPA has contributed to an additional 290 fistula patients receiving repair treatment, which can have a life-altering effect given the social, emotional and physical consequences the condition has for women.[40]

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[37] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021)., p. 37.

[38] Ibid. p. 40.

[39] UNFPA News. (2022) UNFPA, AMREF and Government launch an in-country standard training of fistula Specialized medical teams. Accessed at: https://southsudan.unfpa.org/en/news/unfpa-amref-and-government-launch-country-standard-training-fistula-specialized-medical-teams

[40] See discussion by Adler, Alma & Fox, Samantha & Campbell, Oona & Kuper, Hannah. (2013). *Obstetric fistula in Southern Sudan: Situational analysis and Key Informant Method to estimate prevalence*. BMC pregnancy and childbirth. 13. 64. 10.1186/1471-2393-13-64.

Table 3. Results achievement based on UNFPA reporting toward Outcome 1: Sexual and reproductive health

Outcome and select Output Indicators	2018	Dec 2020
Proportion of births attended by skilled health personnel	14.7%	19%
Modern contraceptive prevalence rate (mCPR)	1.2%	3.2%
Number of people reached with integrated SRH services in displacement and the 14 target facilities	1,505,612	3,166,401
Number of fistula patients repaired with direct support from UNFPA	900	1,190
Number of midwives trained using curriculum that meets ICM and WHO standards	335	553
Percentage of service delivery points that have no stock-out of at least 3 contraceptive methods in the last 3 months	31%	67%

Sources: Baseline data from UNFPA's 2018 Results Framework for the 3rd Country Programme for South Sudan. UNFPA's baseline dataset draws on service data, national socio-economic and SRHR policies. Data from December 2020 derives from the Country Programme Evaluation and is largely based on UNFPA's performance reporting.

Impact on maternal mortality. In South Sudan childbirth and pregnancy are the leading causes of death among women and girls.[41] As we saw, UNFPA contributed to improvements in the use and availability of contraception and the presence of skilled birth attendants, both which are important for reducing maternal mortality.

It is well-documented that family planning and increasing contraceptive use can be critical to addressing maternal mortality in developing contexts. International evidence indicates that increased contraceptive use has reduced the number of maternal deaths in developing countries by approximately 40 percent between 1990 and 2008.[42] Likewise, international evidence indicate that skilled birth attendance is associated with a 20% reduction in death related to intrapartum complications or stillbirth.[43]

FP2030's Family Planning Estimation Tool estimates that ca. 850 maternal deaths have been averted during the programme period (from 2019-2021) as a result of modern contraceptive use. We cannot validate this estimate, nor pinpoint UNFPA's exact contribution to reducing maternal mortality. However, as noted in above, UNFPA was the sole provider of reproductive health commodities to public health facilities in South Sudan during the programme period and thereby has contributed to the outcome at some level.[44] Hence, even though we lack data for the development of maternal

[41] UNICEF. (2017) *Making childbirth safer in South Sudan*. Available at: https://www.unicef.org/stories/making-childbirth-safer-south-sudan. Accessed on July 10, 2024.

[42] Cleland, John & Conde-Agudelo, Agustin & Peterson, Herbert & Ross, John & Tsui, Amy. (2012). Family Planning, Contraception and Health. Lancet. 380. 149-56. 10.1016/S0140-6736(12)60609-6.

[43] Ameyaw, E.K., Dickson, K.S. (2020) Skilled birth attendance in Sierra Leone, Niger, and Mali: analysis of demographic and health surveys. *BMC Public Health* **20**, 164. https://doi.org/10.1186/s12889-020-8258-z

[44] The indicator (# of maternal deaths averted due to modern contraceptive use) is estimated using modelling, calculated in two steps – the first being different outcomes of unintended pregnancies (births, safe/unsafe abortions, miscarriages); and maternal deaths avoided based on the national maternal mortality ratio. Source: FP2030 Measurement Framework.

mortality it is reasonable to conclude that UNFPA contributed to at least some reduction in maternal mortality.

Other impacts

The successful treatment of fistula mentioned above constitute another important impact, even if the scope is somewhat limited, as will be discussed further in Section 5.2. As for other potential impacts we lacked data to assess these.

Outcome Area 2: Adolescents and Youth

Outcome 2 focuses on enabling adolescents and youth to make informed decisions on their sexual and reproductive health and rights, and to participate in policy/ decision-making. In general, the outcome indicator and 2 out of 3 output indicators are very process-oriented, giving little indication of how they contribute to the intended outcome (i.e., (i) number of sectors that have included youth in policies/plans; (ii) number of institutions that have engaged youth in decision-making; and iii) existence of coordination mechanisms on youth). While these highlight that UNFPA largely has been successful in engaging on youth issues, it does not lend itself to analysis of the impact this engagement has had. However, it is notable that UNFPA has sought to integrate comprehensive sexuality education into the school curriculum – even though this seems to be limited to relatively few schools - as this may contribute to prevention of unwanted pregnancies and the spread of sexually-transmitted infections such as HIV.

Table 4. Results achievement based on UNFPA reporting toward Outcome 2: Adolescents and Youth

Outcome and select Output Indicators	2018	Dec 2020
Number of sectors that have mainstreamed adolescents and youth issues in their policies and plans	2 sectors	4 sectors
Number of secondary schools that have integrated sexuality education into school curriculum/programs	20	21

Sources: Baseline data from UNFPA's 2018 Results Framework for the 3rd Country Programme for South Sudan. UNFPA's baseline dataset draws on service data, national socio-economic and SRHR policies. Data from December 2020 derives from the Country Programme Evaluation and is largely based on UNFPA's performance reporting.

Outcome Area 3. Gender Equality and Women's Empowerment

Under Outcome 3 on GEWE, the main focus has been on the elimination of SGBV and harmful practices such as child marriage. SGBV undermines the security of women and girls, inflicting physical, sexual and emotional harm, often with no recourse (*human security).* A 2022 report submitted to the UN Human Rights Council by the Commission on Human Rights in South Sudan highlighted the gravity of the situation ("*perilous situation of insecurity"*) for women and girls in South Sudan, as a result of

widespread and systematic SGBV, and lack of accountability.[45] The report highlights structural, historical and cultural/social root causes of conflict-related SGBV:

"The causes of sexual violence in armed conflict are multiple and complex. Sexual and gender- based violence against women and girls in South Sudan is also structural in nature, and ranges from domestic violence to sexual violence in conflict. Patterns of violence are historically based on entrenched patriarchy, centring on male dominance and control of resources, which also encompasses the exploitation of women, where the female body is perceived as 'territory' to be owned and controlled by males. Rape and sexual violence in South Sudan are underpinned by male dominance and privilege that constructs violence against women as permissible, along with other forms of violence. This fuels impunity for rape and sexual violence crimes and is compounded by the weakness or complete absence of state institutions, including judicial authorities, particularly at local levels."[46]

In this way, the report underscores the need for a multi-pronged approach like UNFPA's (as part of Outcome 3), to address the structural barriers within the legal framework, as well as working with community leaders to shift social norms and practices. However, it also highlights the immensity of the issue in the South Sudan context, where a programme approach and timeframe inevitably will fall short. Unfortunately, UNFPA and the country programme evaluation were unable to find data on UNFPA's outcome indicators for the outcome on gender equality and women's empowerment (GEWE) (see Table 5 below), leaving only output/activity-level data for the impact assessment. Nonetheless, there are some indications of higher-level changes in terms of community support to eliminate child marriage, and the availability of services for survivors of (S)GBV, discussed below:

- ***Community engagement on the elimination of child marriage.*** While the country programme evaluation states "engagement of stakeholders especially at the subnational leadership, religious and cultural leaders have been key to achieving major inroads for mobilizing multisectoral efforts to address harmful traditional practices," it does not substantiate further.[47] Nevertheless, we found the statement valid based on UNFPA's routine monitoring data, as well as key informant interviews with UNFPA's implementing partners in South Sudan, who confirmed that the programme's community engagement activities have led to tangible public resolutions and localised action plans against child marriage.[48]

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[45] OHCHR. (2022). *Conflict-related sexual violence against women and girls in South Sudan: Conference room paper of the Commission on Human Rights in South Sudan.* https://www.ohchr.org/sites/default/files/2022-03/A_HRC_49_CRP_4.pdf

[46] Ibid, p. 3.

[47] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p.61.

[48] UNFPA's Annual Report from 2021 highlights that all 10 states and administrative areas have prepared localised action plans against for ending child marriage based on a review conducted with the paramount chiefs; moreover, 14 communities have also developed public resolutions to end child marriage and GBV. (p. 32.)

- ***Scale-up of One-Stop-Centres (OSCs) for GBV survivors.*** The country programme established 13 new OSCs (formerly only 1 existed) to provide GBV response services around the country. The country programme evaluation highlighted the value these have had to beneficiaries, who have received counselling, medical attention, and legal advice.[49] However, it was also highlighted that these OSCs should integrate economic services and opportunities for survivors, which would alleviate economic dependence e.g., on an abusive spouse, and ultimately break the cycle of violence. In general, the evaluation highlights a shortcoming across not only UNFPA's intervention, but also other donors, in focusing on the provision of services to respond to (S)GBV, with less attention to- and investment in prevention – hereunder changing norms, mindsets, and customary practices.[50]
- ***Addressing the policy & legal framework.*** According to the country programme evaluation, UNFPA has also contributed to the development of a Strategic National Plan on Ending Early and Child Marriages, and in the drafting of an anti-GBV bill;[51] moreover, UNFPA highlighted the country programme's instrumental role in the development of the National Chiefs' Declaration on Ending Child Marriage. However, as noted above in relation to the theory of change, the programme's M&E framework and choice of indicators, as well as the omission of impact-level analysis in the evaluation, makes it difficult to ascertain the effect or impact of these policy-level changes on child marriage practices and GBV respectively. In fact, the UN Common Country Analysis for South Sudan (2023) highlights that South Sudan's "constitutional, legal and policy framework for gender equality and women's economic empowerment [is] broadly progressive. South Sudan has signed up to all the main international and regional treaties and protocols," but these are not systematically implemented or enforced.[52] Thus, the mere existence of *formal institutions* (rules/ laws) such as a policy against child marriage/GBV does not necessarily equate to *informal institutions* (norms / behaviour/ practices) aligned with the elimination of these practices. UNFPA acknowledges the difference between the existence and operationalisation of these frameworks, but also highlighted that behavioural change is a long-term process, that takes more time than a country programme period. Moreover, UNFPA's M&E team highlighted that there are some positive indications – such as the introduction of specific police unites and GBV courts – that attest to implementation of the anti-GBV bill.

[49] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p.46.

[50] Ibid, p.46.

[51] Ibid, p.45.

[52] UN Resident Coordinator's Office. (2023). *South Sudan UN Common Country Analysis (CCA).* p.45-46.

Table 5. Results achievement based on UNFPA reporting toward Outcome 3: Gender Equality and Women's Empowerment

Outcome and select Output Indicators	2018	Dec 2020
Percentage of women aged 20-24 years who were married or in a union before age 18	45%	No data
Percentage of respondents who find it justifiable for men to beat their wives or partners for any reason	74%	No data
Number of communities that make public declarations to eliminate child and forced marriage, with support from UNFPA	0	15
Number of "One-Stop" centres established within public health facilities for multi-sectoral case management of gender-based violence	1	11

Sources: Baseline data from UNFPA's 2018 Results Framework for the 3rd Country Programme for South Sudan. UNFPA's baseline dataset draws on service data, national socio-economic and SRHR policies. Data from December 2020 derives from the Country Programme Evaluation and is largely based on UNFPA's performance reporting.

Outcome Area 4. Population Dynamics and Demographic Intelligence

The final outcome has focused on improving national systems for the generation and dissemination of population data, to strengthen evidence-base and accountability in planning and decision-making. UNFPA has engaged in capacity development of the National Bureau of Statistics (NBS), the country programme evaluation was not able to *fully* assess the effect of this capacity assessment[53], nor did the support lead to the intended outcome of generating national data on population dynamics. According to the evaluation, shortcomings in relation to outcome 4 were due to inadequate human resources in UNFPA, weak capacities within the NBS, lack of financial resources from the Government, and more broadly governance issues within the Government of South Sudan.[54]

Table 6. Results achievement based on UNFPA reporting toward Outcome 4: Population Dynamics and Demographic Intelligence

Outcome and select Output Indicators	2018	Dec 2020
Existence of a population report based on satellite imagery	No	No
Number of evidence-based national and sectoral policies, plans and programmes that integrate population dynamics	2	4 (Health, Education, Gender, Youth)

Sources: Baseline data from UNFPA's 2018 Results Framework for the 3rd Country Programme for South Sudan. UNFPA's baseline dataset draws on service data, national socio-economic and SRHR policies. Data from December 2020 derives from the Country Programme Evaluation and is largely based on UNFPA's performance reporting.

[53] The evaluation was not able to assess the degree to which staff capacities changed; it did however that UNFPA staff and NBS staff indicated that there was progress toward capacity building of the NBS to generate, analyse, produce and disseminate statistical reports.

[54] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021). p. 48-49.

5.2 "SCALE" OF IMPACT

As described above, it can be said that largely the programme has been successful in achieving targeted results and having an impact on particularly sexual and reproductive health (under Outcome 1). But the question remains, what scale of impact has been achieved?

There are several dimensions that speak to the scale or extent of the impact of an intervention[55], but this analysis will focus on the reach of the programme (i.e., the number of people that have experienced positive outcomes), and the depth of the change (i.e., how transformative the changes/outcomes have been). The final dimension, duration, i.e. whether the impact is short-lived or constitutes a lasting change will be discussed further in Section 3.4 on Systemic Impact & Sustainability.

Below is some analysis of the scale of impact, both in terms of reach and depth, on the biggest intended outcomes/impact areas of UNFPA's country programme:

- ***Large-scale impact on the availability of SRH services.*** Over 1.5 million individuals were reached with integrated sexual and reproductive health services in displacement, and at UNFPA's 14 target facilities. The Minimum Initial Service Package (MISP) for reproductive health that UNFPA has implemented included Clinical Management of Rape, Emergency Obstetric and Newborn Care, and Post Abortion Care. One hundred condom dispensers were also installed at different outlets in order to increase access to family planning, particularly targeting youth. The country programme evaluation did not include impact as an evaluation criterion and therefore sheds little light on the scale of impact, other than to highlight that SRH/GBV services are critical in displacement contexts, where women and girls are at even greater risk of SGBV.

- ***Impact on maternal mortality.*** FP2030's modelling estimates that approximately 850 maternal deaths have been averted during the programme period (from 2019-2021) as a result of modern contraceptive use.[56] The ET cannot validate this estimate, nor pinpoint UNFPA's exact contribution to reducing maternal mortality. However, UNFPA was the sole provider of reproductive health commodities to public health facilities in South Sudan during the programme period and thereby has contributed to the outcome at some level.

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[55] The framework and definitions used to assess the scale of impact are inspired by Impact Frontiers' Five Dimensions of Impact. Source: Impact Frontiers (N.D.) *Five Dimensions of Impact: How Much?* Accessed on 1 November 2024. Available at: https://impactfrontiers.org/norms/five-dimensions-of-impact/how-much/

[56] The indicator (# of maternal deaths averted due to modern contraceptive use) is an estimated using modelling, calculated based on two steps – the first being different outcomes of unintended pregnancies (births, safe/unsafe abortions, miscarriages); and maternal deaths avoided based on the national maternal mortality ratio. Source: FP2030 Measurement Framework.

- ***Impact on human resources (midwives) to ensure skilled birth attendance.*** At independence in 2011, South Sudan had only 8 trained midwives, but in 2019, this had increased to 700.[57] UNFPA's country programme and other project support has contributed to this increase in the supply of midwives, with 218 midwives trained as part of country programme. As noted in Section 5.1, skilled birth attendance is linked a significant (20%) reduction in maternal, foetal, and neonatal mortality.[58] While the rate of births attended by skilled health personnel has improved in South Sudan, the vast majority of births still take place outside of health facilities without skilled birth attendants.

- ***Fistula repair.*** As highlighted above in Section 5.1, UNFPA has supported 290 fistula patients in fistula repair surgery and treatment. Noting that a backlog of approximately 59,000 fistula patients remains, this impact is not of a very large scale. Nevertheless, the depth of impact cannot be understated, given the severe health, social and psychological consequences that fistula patients suffer.

- ***Policy level changes on GBV and child marriage.*** In theory, addressing structural challenges that enable GBV and child marriage practices to prevail, and impunity for perpetrators, should have a broad impact (reach). We have not been able to ascertain the depth of that impact, but UNFPA's gender specialist highlighted that traditional leaders play a very significant role in South Sudan.

- ***No evidence of tangible impacts in terms of the availability of data on population dynamics/demographics.*** As noted above, at outcome level, UNFPA fell short of the envisioned effect on national systems' ability to generate and disseminate population data. While UNFPA's staff highlighted that there has been an increase in the capacity of staff in the National Bureau of Statistics, we have not found evidence to signal this has had an impact on the availability of data on population dynamics/demographics.

The above analysis highlights the different scales of impact derived from UNFPA's country programme but also serve to illustrate the challenges related to quantifying/qualifying impacts related to policy advocacy and reform, which has been one of UNFPA's strategic intervention approaches.

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[57] UNPFA News: "*From 8 to 700 midwives in 8 years, South Sudan is making huge strides in saving mothers' lives, with UNFPA support.*" 11 June 2019. Accessed at. https://esaro.unfpa.org/en/news/8-700-midwives-8-years-south-sudan-making-huge-strides-saving-mothers%E2%80%99-lives-unfpa-support

[58] Ameyaw, E.K., Dickson, K.S. (2020) Skilled birth attendance in Sierra Leone, Niger, and Mali: analysis of demographic and health surveys. *BMC Public Health* **20**, 164. https://doi.org/10.1186/s12889-020-8258-z

5.3. IMPACT FOR SPECIFIC TARGET GROUPS

The evaluation of the country programme highlights that the interventions were based on a needs assessment of priority population needs. While the overarching target group was women and girls, including in GBV survivors and/or in displacement contexts, UNFPA has also sought to reach people living with disabilities, and at-risk groups such as sex workers. Under Outcome 2, the programme has also targeted youth and adolescents more broadly, also to enable their access to SRH services, and to increase their knowledge and awareness of SRHR and family planning.

The evaluation of the country programme confirms that UNFPA's areas of coverage correspond with the aim to reach the most hard-to-reach and vulnerable population groups, particularly through the focus on displacement-affected communities. The evaluation does not point to specific impacts on the most vulnerable/at-risk target groups (e.g., people living with disabilities and/or sex workers), and concludes that "the program targeting and reach to some of the vulnerable populations, especially people with disabilities, has not been explicit".[59]

Thus, in light of this statement, the ET finds that UNFPA has had an impact for women and girls who have received SRH and GBV services, including in displacement contexts (as indicated above in Section 3.2); however, the country programme has not had a *documented* effect or impact for the most vulnerable populations – hereunder persons living with disabilities and sex workers. It should however be noted that UNFPA engages sex workers in South Sudan through other funding streams, providing SRH, GBV and HIV services, but does not provide reporting on these target groups under the auspices of the country programme.[60]

5.4. SYSTEMIC IMPACT AND SUSTAINABILITY

Much of the impact in the above sections relates to service delivery, where systemic impact and sustainability inherently are a challenge in a context like South Sudan. UNFPA is cognisant of the challenge of working through- and strengthening national systems, noting:

> *"There has been government over-reliance on donor funding to finance critical social services. Government financing of own development efforts continued to suffer setbacks occasioned by lack of national resources. For example, out of the $584 million national budget for the 2018/19 Fiscal Year, about 45 percent of the budget was allocated to wages and salaries. The health sector allocation was only 1.9 percent of the total national budget and this has reduced to 1.1*

[59] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021)., p. 64.

[60] Reported on in UNFPA's annual reports in South Sudan which cover multiple funding streams (projects) in addition to the country programme.

> *percent in the 2019/2020 budget. Despite the destruction during the war and the poor physical condition of most health facilities, there is no allocation to infrastructure development for the health sector. There has been limited investment in health system capacity development, particularly low employment and deployment of health care providers especially midwives in the health sector; irregular payment of health workers' salaries resulting in low motivation, poor attitude to work and absenteeism; and the sporadic provision of essential drugs and supplies coupled with a weak logistics management system."*[61]

Despite efforts in Outcome Area 1 to strengthen national systems for maternal health and family planning, achieving sustainable government ownership remains a significant challenge. The government lacks the institutional capacity, financial resources, and, most critically, the political commitment needed to maintain the services and systems established by the international community. As a result, the programme continues to face persistent challenges, including inadequate training for healthcare professionals, high staff turnover, delayed or unpaid salaries, and chronic shortages of essential medicines and medical equipment in health facilities.[62]

Under Outcome 4 (related to data on population dynamics), UNFPA set out to capacity key national stakeholders, hereunder the NBS, but as noted above, difficulties in relation to funding, organisation, capacities, and staff turnover impeded results achievement.

Nevertheless, other elements of UNFPA's intervention are in our view likely to have a systemic impact, hereunder the training of midwives and incremental changes noted in the skilled birth attendance rate. The country programme evaluation highlights that the establishment of a professional midwifery association alongside the programme implementation likely will support sustainability, and that the Government has explored options for financial sustainability by having trainees pay a fee in relation to the training.[63]

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[61] UNFPA. (N.D). Terms of Reference for United National Population Fund (UNFPA) South Sudan 3rd Country Programme Evaluation. P. 1.

[62] The issue of gaps in delivery between implementation phases was discussed in interviews with FCDO in relation to the Health Pooled Fund. FCDO highlighted the gaps in service delivery that have occurred when the HPF (or the World Bank in the two states where the HPF does not operate) experienced funding gaps or pauses implementation between one phase and the next.

[63] Odimegwu, C.O., Logo, K. H., and J.M. Mwesigwa. (2021)., p. 54.

6 Conclusions

The overall conclusion from this analysis of UNFPA's third country programme is that UNFPA has had an impact in terms of availability, access and use of SRH and GBV services in South Sudan. The case study also highlights the breadth of UNFPA's engagement—not only through its five 'modes of engagement' but also across the diverse arenas where it has sought to drive change.

While it has been difficult to measure the impact(s) of UNFPA's policy level engagement – as well as what the actual systemic effect(s) have been of engaging with the Government of South Sudan to develop national capacities, guidelines and plans – the case study has been able to shed light on the impacts of UNFPA's service delivery and training activities.

In particular, our study shows that the country programme's focus on training and deployment of midwives led to increases in skilled birth attendance, which is directly linked to reduced maternal mortality. The programme also had a profound impact on mothers living with obstetric fistula who received successful treatment, and survivors of sexual and gender-based violence who were received support and services.

Given the severity of needs for SRH and GBV services in South Sudan, which have been highlighted throughout this case study report, UNFPA's support has been critical to ensuring that over one million women and girls (including in displacement contexts) have had access to SRH and GBV services. The impact of such support for women and girls should not be understated; but on the other hand, it is necessary to point out that the service delivery approach driven by the international community falls short in terms of sustainability, particularly as UNFPA now launches its 4th country programme in South Sudan. The Government of South Sudan currently does not have the capacity nor financial resources to maintain the level of service delivery in the short- to medium term.

The Third UNFPA Country Programme for South Sudan (2019-2022) aimed to ensure universal access to sexual and reproductive health and rights, and to reduce maternal mortality in South Sudan. UNFPA partnered with the Government of South Sudan to strengthen national healthcare systems and deliver integrated sexual and reproductive health information and services. It also provided direct support to crisis-affected populations, particularly women and youth.

Main evaluation method: Desk review of monitoring data, reports and relevant research.

Positives: UNFPA improved the availability and use of sexual and reproductive health and gender-based violence services in South Sudan, ensuring access for more than one million women and girls, including those affected by displacement. The training and deployment of midwives led to increases in skilled birth attendance, which is directly linked to reduced maternal mortality.

Potential shortcomings: It was difficult to achieve sustainable government ownership. The government lacks the institutional capacity, financial resources, and the political commitment needed to maintain the services and systems established by the international community. Challenges included inadequate training for healthcare professionals, high staff turnover, delayed or unpaid salaries, and chronic shortages of medicines and medical equipment.

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