Investment Cases Towards Ending Unmet Need for Family Planning, Preventable Maternal Deaths, and Gender-Based Violence

SOUTH SUDAN

SYNTHESIS REPORT
September 2021
1. COUNTRY CONTEXT

South Sudan, a low-income country, is the world’s youngest country since attaining independence in 2011 and has a population of about 13.2 million as of 2020. The majority of the population (73.7 per cent) is below 30 years old and 81.0 per cent live in rural areas. The humanitarian crisis in South Sudan remains complex and protracted, with both acute and chronic needs experienced at varying levels across the country. Decades of war, intercommunal clashes, frequent disease outbreaks, flooding and drought, and a weakening economy continue to ravage the country and have undermined national capacity for provision of people-centered services. By the end of March 2020, four million people remained displaced by the humanitarian crisis: two million internally displaced and more than two million refugees.¹

South Sudan is one of the most oil-dependent countries in the world, with oil accounting for almost all its exports and more than 40 per cent of its gross domestic product (GDP). The country’s GDP per capita in 2014 was $1,111, which dropped to less than $200 in 2017.

Outside the oil sector, livelihoods are concentrated in low productive, unpaid agriculture and pastoral farming. Coupled with economic difficulties, years of conflict have eroded the country’s productive capacity.

Maternal mortality rate is high at 789 deaths per 100,000 live births. 80% of women deliver at home, assisted by untrained attendants.

With declining consumption, non-oil exports and investment, oil production remains the immediate source of revenue in South Sudan. As a result, South Sudan continues to underinvest in key sectors, including health, education, agriculture, youth employment, tourism, and mining, which would have significant impact on poverty reduction. It is estimated that about 80 per cent of South Sudanese live below the poverty line. With the declining economy, there has been an over-reliance by the Government on donor funding to finance critical social services and humanitarian response as the Government’s financing for development has continued to suffer setbacks.

South Sudan’s maternal mortality rate is high, with an estimated 789 maternal deaths per 100,000 live births (UN estimate, 2015). Skilled attendance during delivery is 19 per cent, with 80 per cent of women delivering at home, assisted by untrained attendants. The total fertility rate is 7.5 children per woman, and the adolescent birth rate is 158 per 1,000 girls aged 15-19 years. Family planning service uptake is extremely low in the country, with an estimated 96 per cent of women aged 15-49 years currently married or in a union unable to use or access modern family planning method. Only 1 per cent of a total of 4 per cent are reported to use modern family planning methods. The unmet need for family planning in South Sudan was at 29.7 per cent in 2020. Contraceptive prevalence rate for all methods was estimated at 4 per cent in 2010, while the prevalence rate for modern methods among users of contraception was at 5 per cent as of 2015.

Gender inequality and gender-based violence are widespread, perpetuated by cultural norms, and further exacerbated by conflict and displacement. Adolescent reproductive health status in the country is poor, with teenage pregnancy estimated at 30 per cent among girls 15-19 years old. The 2010 Household Heath Survey indicates that 45 per cent of South Sudanese girls enter marital union before the age of 18, an increase from 41 per cent in 2006. Child marriage is a violation of a child’s rights and presents gross consequences for individuals and society alike.

1.1 Making a case for investing in SRHR transformative results

In response to the challenges in the country, government and partners, including UNFPA, have designed country programmes to improve the situation in South Sudan by embracing human rights and gender equality principles.

An estimated 96% of women aged 15-49 years currently married or in union are unable to use or access modern family planning method. The unmet need for contraception in 2020 was at about 30%.

---

and align with the National Development Strategy (NDS) (2018-2021), the United Nations Sustainable Development Cooperation Framework (UNSDCF) (2019-2021), the Sustainable Development Goals (SDGs). The programmes are designed to deliver integrated results that will contribute to the achievement of the “three zeros” (transformative results) of zero unmet need for contraception; zero preventable maternal deaths; and zero gender-based violence (GBV) and harmful practices (including female genital mutilation (FGM), child marriage, as well as the East and Southern Africa (ESA) regional flagship result of ending sexual transmission of HIV.

In addition, the programmes contribute directly to the achievement of SDGs 3 and 5 and indirectly to SDGs 10, 16 and 17.3

The country-level investment cases present an opportunity for South Sudan to assess the scale and scope of investments needed to prioritize proven, high-impact and cost-effective interventions that are required to accelerate progress towards the achievement of the transformative results committed to by government and partners. The investment cases are therefore expected to inform partnership efforts and mobilization of additional domestic and external financing required to achieve the transformative results. In this regard, recognition of the continuously evolving sustainable financing landscape, situating country-level investments within the development, humanitarian and peace nexus is critical.

1.2 Priority interventions

The analysis of ending preventable maternal deaths focused on 27 high impact interventions that have been shown to reduce and end preventable maternal deaths globally. These priority interventions are along the continuum of maternal care, namely: 1) peri-conceptual, 2) pregnancy, 3) childbirth, 4) preventive care, and 5) curative care.

For the transformative result of ending the unmet need for family planning, seven different components of modern contraception were considered in consultation with the National Reference Group (NRG). These included: 1) male condoms, 2) female sterilization, 3) 3-month injectable 4) Implants-Implanon (3 years), and Jadelle (5 years), 5) intrauterine devices (IUD)-Copper-T and LNG-IUD, 6) pills, and 7) traditional methods (withdrawal, periodic abstinence, and non-specified methods).

In estimating the transformative result of ending child marriage in South Sudan, a set of cost-effective Child Marriage Optimal Interventions (CMOI) in education and the community considered to ‘hold great promise to reduce incidence of child marriage’ in a cross-section of countries, were factored in. Sub-interventions in education included rural school services, improved school infrastructure, pedagogical changes and improvements, cash transfers, and malaria interventions. Key elements of the community interventions included community mobilization, conditional economic incentives, and life skills.

Lastly, in estimating the transformative result of ending GBV, the model prioritizes Intimate Partner Violence (IPV) and accounted for limited medical treatment, including counselling only for rape victims who report the incident. As such, the costs should be considered as the minimum.

---

3 SDG 3: “Ensure healthy lives and promote well-being for all at all ages”; SDG 5: “Achieve gender equality and empower all women and girls”; SDG 10: “Reduce inequality within and among countries”; SDG 16: “Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.”; SDG 17: “Strengthening the means of implementation and revitalize the global partnership for sustainable development.”
1.3 Scale of effective coverage of priority interventions

Different effective coverage scenarios of the priority interventions were developed in consultation with the NRG. The baseline and endpoint for all the coverage projections are 2020 and 2030, respectively, and the first year of impact of the interventions is 2021. With regard to ending maternal deaths and ending unmet need for family planning, four different effective coverage scenarios were considered.

The first scenario assumes that South Sudan will continue at the current baseline coverage rate for maternal health interventions. This means that there will be no change in coverage of selected high impact maternal health interventions from 2020 through 2030. In the case of family planning, this scenario assumes that the current rate of contraception will continue without any policy intervention changes.

In scenario 2, the projection sets a modest policy target of scaling up coverage of all priority maternal health interventions from the baseline to 30 per cent by 2030 based on the Government’s plans such as the Reproductive, Maternal, Newborn and Child Health and Nutrition (RMNCAH&N) (2018-2022), the costed Boma Health Initiative (2019), and the National Health Policy (2016-2026) among other national and international initiatives. This translates to an average coverage scale-up of about 1.5 per cent to 3 per cent annually of high impact maternal interventions from the baseline. For family planning, this scenario sets a modest policy target of scaling up the modern contraceptive prevalence rate to 30 per cent of coverage by 2030 and reducing traditional contraceptive methods to zero over time. This is in line with the policy focus of the Government that seeks to achieve a modern contraceptive prevalence rate (MCPR) of between 30 per cent and 40 per cent. In this projection, the lower limit of the policy target was used.

In scenario 3, the projection sets achievable policy targets of scaling up coverage of all priority interventions from the baseline to 50 per cent by 2030 based on the Government plans. This translates to an average coverage scale-up of about 2 per cent to 5 per cent annually of selected maternal interventions. For family planning, the scenario considered an achievable target of increasing the modern contraceptive rate from 5 per cent to 40 per cent by 2030 and reducing traditional contraceptive methods to zero over time. This projection used the upper limit of the policy goal of the Government. This requires several interventions to scale up use of modern contraception compared to the currently dominant traditional methods.

The projection for scenario 4 sets ambitious policy targets of scaling up coverage of all priority interventions to 100 per cent by 2030 in accordance with universal health coverage per the SDG commitments. This translates to an average coverage scale-up of about 10 per cent annually of selected high impact maternal interventions. For family planning, this scenario seeks to achieve an extremely high target of the modern contraceptive prevalence rate. The scenario assumes an increase in the modern contraceptive rate from the current 5 per cent to 50 per cent by the end of 2030 and a reduction in traditional contraceptive methods to zero over time. The scenario was considered ambitious as it lies outside the 30 per cent to 40 per cent target set by the Government.

For ending child marriage, the Child Marriage Optimal Interventions (CMOI) was estimated to reduce child marriage to 5 per cent by 2030. This target is also in line with the African Union’s Plan of Action (AUPA) and the UN SDG target of ending child marriage by 2030. Finally, the effective coverage of ending GBV was based on the assumption that South Sudan will reach at least 5 per cent of the target population in 2021 and an additional 5 per cent annually.

---

4 National commitment for accelerating the promise of international conference on population and development, 2019.
1.4 Impact and costs of meeting the transformative results

A summary of the impact and cost of scaling up effective coverage of high-impact interventions required to achieve the transformative results is summarized in Table 1 and listed below.

Ending preventable maternal deaths

i. An achievable (50 per cent) scale-up of coverage of 27 high impact maternal health interventions, including contraceptive use, could save over 5,500 maternal lives over the next 10 years at a total cost of $408 million, requiring an incremental (additional) funding of $318 million. This could avert over 33 per cent of maternal deaths compared to the status quo and reduce the maternal mortality ratio by over 30 per cent from 789 deaths per 100,000 live births in 2020 to 530 deaths per 100,000 live births by 2030, as illustrated in Figure 1.

ii. An ambitious and universal scale-up of the 27 high impact interventions to 100 per cent coverage could save over 8,800 maternal lives and would require an additional cost of $530 million over the next 10 years. This could avert over 50 per cent of maternal deaths compared to the status quo and reduce the maternal mortality ratio by 51 per cent from 789 deaths per 100,000 live births in 2020 to 386 deaths per 100,000 live births by 2030.

iii. From 2020 to 2030, $90 million is estimated to be available and committed by the Government, donors, and others to finance the reduction of preventable maternal deaths.

iv. In summary, the additional funding needed to reduce preventable maternal deaths is $318 million for the achievable coverage projection scenario and $530 million for the ambitious scenario.

Figure 1: Trends in maternal mortality ratio (deaths per 100,000 live births) by coverage scenario, 2020-2030

An achievable (50%) SCALE UP OF COVERAGE OF HIGH IMPACT MATERNAL HEALTH INTERVENTIONS could reduce maternal mortality ratio from 789 per 100,000 live births in 2020 to 530 per 100,000 live births by 2030.
Ending unmet need for family planning

i. Raising the modern contraceptive prevalence rate to between 30 per cent to 50 per cent, with a view to ending unmet need for family planning, will increase the number of unintended pregnancies averted from 292,075 under the status quo to between 1,084,243 and 1,717,979 from 2020 to 2030 across the three scenarios — modest (30 per cent), achievable (40 per cent) and ambitious (50 per cent).

ii. Likewise, increased contraceptive prevalence will also increase the number of unsafe abortions averted from 98,137 under the status quo to between 364,305 and 577,241 across the three scenarios by 2030.

iii. The number of maternal deaths averted with increased modern contraceptive prevalence is also expected to increase from 3,202 under the status quo scenario to between 11,960 and 19,014 in total by 2030 across the three scenarios.

iv. The scale-up in contraceptive prevalence will require a total incremental (additional) cost of between $21 million and $35.8 million across the three scenarios. The incremental costs by main component are shown in Figure 2. The main cost driver is drugs and supply costs.

v. Given the estimated available government resources, the funding gap to achieve coverage ranges from $20.19 million to $34.96 million across the scenarios.

Given the estimated available government resources, the funding gap to achieve scaled up contraceptive coverage from $20.2 million to about $35 million.

Ending child marriage

i. Without interventions, over two million children are likely to be married in the next 10 years. However, with targeted interventions, 62 per cent of child marriages (about 1.4 million) would be averted.

ii. The total cost of reducing child marriages to 5 per cent in South Sudan would be $605.60 million.

iii. Community intervention accounts for the greater proportion of the cost at $512 million, constituting 84 per cent of the total. Education intervention accounts for about $93.60 million.

iv. On average, $503 is required to avert one case of child marriage in the country within the next decade.

Given the estimated available government resources, the financing gap to achieve scaled up contraceptive coverage from $20.2 million to about $35 million.

Figure 2: Summary of incremental costs by main component, by scenario
Ending GBV and all harmful practices

Without any intervention, the number of women experiencing intimate partner violence (IPV) in the country would increase from 592,219 in 2020 to 3 million by 2025 and an additional 3.12 million by 2030.

With a 5 per cent annual increase in the effective coverage of targeted interventions, the number of women experiencing IPV in South Sudan would be reduced. Between 2021 and 2025, 171,708 cases of IPV would be averted; an additional half a million cases would be averted by 2030. With a 50 per cent intervention coverage for all indicators, 392,376 cumulative cases of IPV would be averted during 2021-2025 and an additional 2.3 million cases during 2026 through 2030.

Achieving these outcomes would cost $87.6 million, with economic empowerment interventions representing about 60 per cent of the total. This is followed by community mobilization and programme support, each accounting for 13 per cent.

Table 1: Summary of costs, impacts, and funding gaps of interventions, 2020-2030

<table>
<thead>
<tr>
<th>MATERNAL HEALTH INTERVENTION</th>
<th>MODEST PLAN (30%)</th>
<th>ACHIEVABLE PLAN (50%)</th>
<th>AMBITIOUS PLAN (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total intervention cost ($ million)</td>
<td>313.36</td>
<td>408.10</td>
<td>619.55</td>
</tr>
<tr>
<td>Impact: Maternal lives saved</td>
<td>3,488</td>
<td>5,570</td>
<td>8,802</td>
</tr>
<tr>
<td>Funding gap, 50% scenario ($ million)(%)</td>
<td></td>
<td>317.82 (78%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UNMET NEED FOR FAMILY PLANNING</th>
<th>MODEST PLAN (30%)</th>
<th>ACHIEVABLE PLAN (40%)</th>
<th>AMBITIOUS PLAN (50%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total intervention cost ($ million)</td>
<td>21.0</td>
<td>28.33</td>
<td>35.82</td>
</tr>
<tr>
<td>Impacts of intervention:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of unintended pregnancies averted due to modern method use</td>
<td>1,084,243</td>
<td>1,401,111</td>
<td>1,717,979</td>
</tr>
<tr>
<td>Number of maternal deaths averted due to modern method use</td>
<td>11,960</td>
<td>15,500</td>
<td>19,014</td>
</tr>
<tr>
<td>Number of unsafe abortions averted due to modern method use</td>
<td>364,305</td>
<td>470,774</td>
<td>577,241</td>
</tr>
<tr>
<td>Funding gap ($ million) (%)</td>
<td>20.19 (95.74%)</td>
<td>27.60 (96.85%)</td>
<td>34.96 (97.50%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENDING CHILD MARRIAGE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost ($ million)</td>
<td>605.60</td>
</tr>
<tr>
<td>Impact: Child marriages averted</td>
<td>1,400,000 (62%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENDING GBV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost of interventions ($ million)</td>
<td>87.57</td>
</tr>
<tr>
<td>Impact: Cumulative cases of GBV averted with 50% intervention coverage increase</td>
<td>2,664,987</td>
</tr>
</tbody>
</table>
2. COUNTRY STRATEGIES TO ACHIEVE THE SDGS AND ICPD25 COMMITMENT

The Government of South Sudan has made a number of commitments to improve the country’s sexual and reproductive health and outcomes.

For instance, the family planning 2020 commitment aims to improve access to family planning information and services through provision of integrated and rights-based sexual and reproductive services; reducing maternal mortality; and increasing modern contraceptive rates among married women. The country strategy, at a policy level, has created an enabling environment through protocols, guidelines, and tools to support integrated sexual reproductive health services and reproductive health rights. Increased access to reproductive health information and services is being addressed through the implementation of the National Health Policy (NHP), Health Sector Strategic Plan (HSSP), and the Boma Health Initiative (BHI), and the development of a national action plan to combat early child marriages and GBV. South Sudan has also made a funding commitment to increase the allocation of national budget to health and establish a dedicated budget line in the Ministry of Health for reproductive health and family planning.

Other strategies include increasing access to reproductive health information and services at all levels to reach all populations through the public and private sectors. The country also aims to strengthen the supply chain management for reproductive, maternal, neonatal, and child health to minimize stock-outs and ensure last-mile delivery in all sectors.

3. SUSTAINABLE FINANCING FOR THE TRANSFORMATIVE RESULTS

3.1 Financing gaps to meet the costs of “Getting to Zero”

A total investment of $408 million would be required towards ending preventable maternal deaths under the achievable scenario through 2030. However, the projected financing available to the country from 2020 to 2030 from all sources is estimated to be only $90 million ($7 million from the Government; $63 million from external sources; and $20 million from private sources), leaving a funding gap of $318 million or 78 per cent of the financing requirement. Similarly, ending the unmet need for family planning has a financing gap estimated at 55.11 per cent, 96.85 per cent, and 97.5 per cent in the modest projection scenario, achievable projection scenario, and ambitious projection scenario, respectively.

3.2 Domestic resource mobilization

South Sudan’s health policy advocates for universal health coverage by expanding health financing mechanisms and progressively increasing public health expenditure through increased budget allocation to meet the Abuja commitment as initial steps towards universal health coverage (UHC). One of the objectives of the 2016-2026 Health Policy is the mobilization of health system resources that enable improvements in the health sector performance. To attain UHC as stated in the policy, the Ministry of Health is tasked to mobilize resources that ensure reductions in maternal and neonatal mortality and guarantee sexual and reproductive health services and rights, focusing specifically on vulnerable groups.

South Sudan has not met domestic, regional, and international health financing targets, including the Abuja Declaration, which recommends that countries invest at least 15 per cent of budget in health. However, the 2013-2016 Plan promised to fulfil the Abuja Declaration by allocating 15 per cent of the national budget to health, with a goal of spending $34 per capita on health by 2015. South Sudan’s health financing stands at only 2 per cent annually on average. This has led to the health sector being almost entirely dependent on external aid. This also accounts for high out-of-pocket payments in the country, accounting for an estimated 65 per cent of the total health expenditure, and underscoring the urgent need for the Government to ensure quality services are affordable and accessible to the population.

A total investment of $408 million would be REQUIRED TOWARDS ENDING PREVENTABLE MATERNAL DEATHS under the achievable scenario through 2030.

---

6 Ministry of Health, South Sudan National Health Policy, 2016-2026.
8 Sudan Federal Ministry of Health and University of Khartoum, Sudan National Health Account; 2008.
CONCLUSION

In conclusion, the investment cases provide estimates for support scaling up coverage of selected interventions in South Sudan that will help improve sexual and reproductive health and rights outcomes within the country context.

It presents the costs and impacts of achieving the transformative results of ending unmet need for family planning, ending preventable maternal deaths and ending GBV and other harmful practices such as child marriage. Historical costs were used where data is available, but in some cases where there was no data to support the analysis, data from shadow economies (countries) was used.

As demonstrated by the investment cases, there are priority interventions whose coverage can be scaled up to avert maternal deaths, end unmet need for family planning, and prevent and respond to GBV and harmful practices at estimated costs. To this end, numerous instruments, both laws and policies, have been developed and introduced that need to be better operationalized. The lack of implementation creates a huge gap between policies and practice in the country. Second, due partly to the underlying gaps between policies and practice, the South Sudanese health system remains very fragile. There is a need for strong political will to realize the envisioned outcomes in the sector.

Minimum effort has been made to meet the Abuja target and other African Union health financing targets. An annual spend of 2 per cent of the Government’s budget for the health sector is insufficient to yield any meaningful results from the interventions. To deliver on the various commitments the Government has made, increased investment in the relevant sectors including health, education, and protection sectors are necessary. The results of the investment cases provide the quantifiable basis to support advocacy for increased resources.

The development of the investment cases was limited by some fundamental factors, specifically the absence of updated baseline data. Ideally, the investment cases should have used more recent baseline data on coverage of interventions and prevalence of key indicators. National surveys such as the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) are reliable sources of such information. Unfortunately, South Sudan has not conducted these national surveys in the past decade. Instead, several strategies were used to populate the data, including using baseline data from shadow countries and regional averages, where necessary. These drawbacks call for improvement in the availability, timeliness, and quality of the country’s data and statistics.
SOUTH SUDAN • Investment Cases Towards Ending Unmet Need for Family Planning,
Preventable Maternal Deaths, and Gender-Based Violence