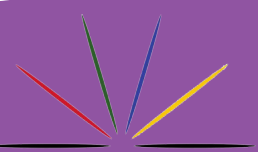




World Vision®



Health Pooled Fund
South Sudan



PRIORITIZING GENDER EQUALITY AND SOCIAL INCLUSION

Across Health
Interventions

WESTERN EQUATORIA,
SOUTH SUDAN



A Gender Equality and Social Inclusion Promising Practice



Canada



Sweden
Sverige



ACKNOWLEDGEMENTS

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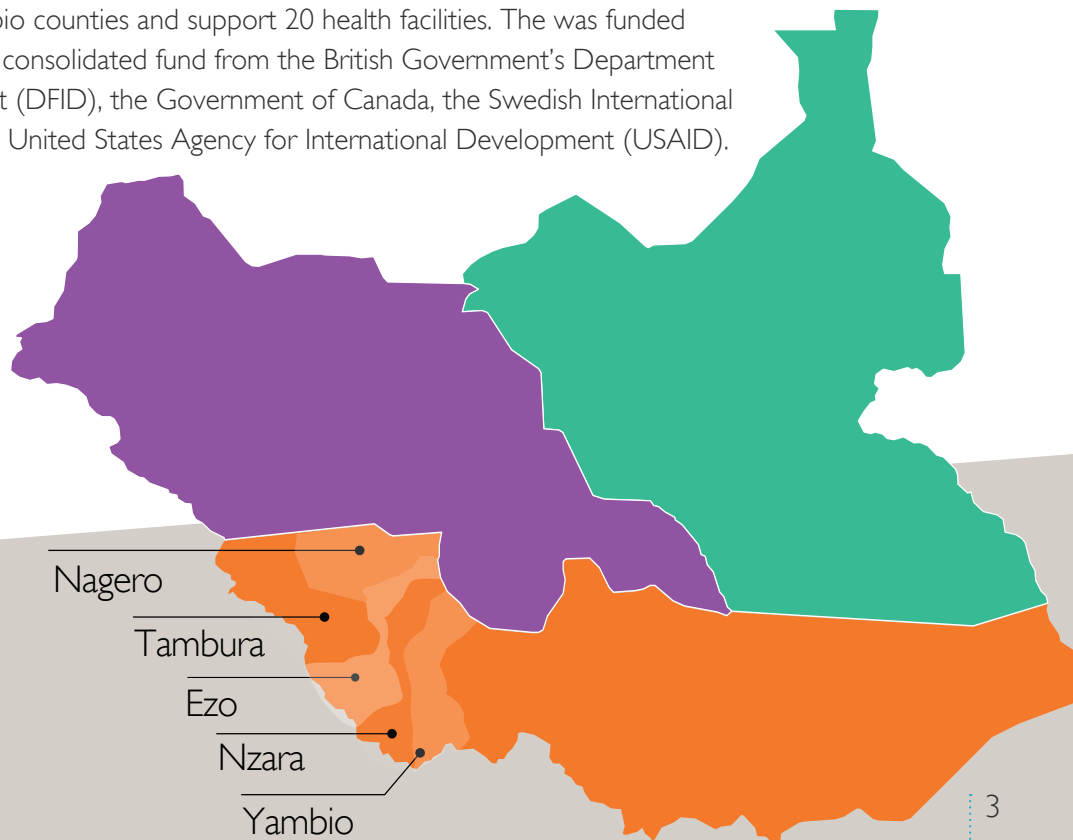
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PRIORITIZING GESI ACROSS HEALTH INTERVENTIONS

This document presents a promising practice on integrating Gender Equality and Social Inclusion (GESI) into the public healthcare system in Western Equatoria, South Sudan, to serve the poor and marginalized members of the community. The major goals of the Prioritizing GESI Across Health Interventions in Western Equatoria project was to ensure equitable access to quality health services for all, support health systems reform; and address the social determinants of health.

The evidence suggests that the project strengthened the health system and referral mechanisms at all levels of health care. Working closely with the Government of South Sudan's Ministry of Health and other partners, the project improved the health status of women, children, and other vulnerable groups including persons with disabilities and survivors of gender-based violence, through an accountable and equitable health service delivery system. The project enhanced health access for the most vulnerable by supporting health facilities in five counties of Western Equatoria, namely Yambio, Nzara, Ezo, Tambura, and Nagero. World Vision South Sudan Health Pooled Fund project was implemented in two Lots: Lot 7 and 8. Lot 7 covers Tambura, Nagero and Ezo counties and support 54 health facilities. Lot 8 covers Nzara and Yambio counties and support 20 health facilities. The was funded by the Health Pooled Fund, a consolidated fund from the British Government's Department for International Development (DFID), the Government of Canada, the Swedish International Development (SIDA) and the United States Agency for International Development (USAID).



THE CONTEXT

The Republic of South Sudan became an independent nation in 2011. After almost 40 years of civil wars between the Sudan government and Southern rebel forces, Sudanese voted in a January 2011 referendum to become independent from Sudan, so South Sudan became an independent nation.¹ Unfortunately, political tension with Sudan, and continued conflicts between the army and rebel groups continue to reoccur, and this has caused death and displacement of millions of people who now live as internally displaced persons (IDPs) or refugees. About 80 % of the population in South Sudan are below the poverty line, living on less than US\$1 a day and many experience severe food insecurity and limited access to health services. About 75 % of the population have little or no access to health services, and this contributes to a high number of preventable deaths.² South Sudan also has the world's highest maternal mortality rates (2,054 per 100,000 live births); a very high infant mortality rate (102 per 1,000 live births) and under-five mortality rate (135 per 1,000 live births); and a life expectancy of 55 years.³ UNICEF reports that more than 92 % of births in South Sudan occur without the presence of a skilled professional. This contributes to South Sudan having the fifth highest maternal mortality rate in the world.

South Sudan's literacy rate for men is 40.26 %, and for women is just 28.86 %.⁴ Women and persons with disabilities (PWDs) continue to remain underrepresented at all levels of employment and education. Low levels of education and lack of employment or access to income generating activities have a particular impact on health outcomes for women, girls, and PWDs as they affect their awareness of health issues, ability to access services and to inform policy and programming and contributes to their increased risks of exposure to sexual and gender-based violence (SGBV).

Furthermore, conflicts, the associated use of rape as a weapon of war, and the resulting displacement have meant that women and girls are at even a greater risk of SGBV and HIV infection, and women and girls' lower social status denies them the opportunity to protect themselves such as failing to negotiate for condom use due to fear. HIV infection predisposes women and girls to violence, such as fear or abandonment by their partners or disinheritance of widows who are accused of infecting their husbands. Social norms perpetuating SGBV are deeply ingrained in the behaviors of both men and women across the country. Research indicates that there is a profound, deeply rooted, and internalized individual acceptance of sexual violence by women and girls as a normal practice that is part of life. One prominent example of the interaction between cultural norms and violence is the issue of child marriage. This remains a common practice in South Sudan, with studies suggesting that 52 % of girls are married before the age of 18.⁵ Women who marry early are at risk of difficult and complicated pregnancies and deliveries which can result in death and injuries.

1 UNDP. 2021. Demographics of South Sudan.

2 UNICEF and World Bank. 2019. Pre-Primary Education in South Sudan: Current Opportunities and Challenges, documents1.worldbank.org/curated/en/825031562606091545/pdf/Pre-Primary-Education-in-South-Sudan-Current-Opportunities-and-Challenges.pdf

3 Mid-Term Review: South Sudan Health Pooled Fund. 2015.

4 UNESCO. 2021. Institute of Statistics, Data for Sustainable Development Goals. uis.unesco.org/en/country/ss

5 Ministry of Health. 2010. South Sudan Household Health Survey.

The African Charter on the Rights and Welfare of the Child prohibits the marriage of any child under the age of 18 years, as does the South Sudan Child Act (2008). Yet, many South Sudanese communities continue to perceive child marriage as being in the best interests of girls and their families, and an important way to access much-needed resources, such as cattle, money, and other gifts via the traditional practice of transferring wealth through the payment of dowries. Child marriage is also related to social structures that ensure power, wealth and family lineage is passed through the male descendants. Furthermore, there is an exceptionally high early pregnancy rate of 65.9 % (births per 1,000 women ages 15–19) attributable to the high rate of child, early and forced marriage. Persons with disabilities (PWDs) are amongst those most vulnerable in South Sudan since they face stigma and numerous cultural, attitudinal, environmental, and institutional barriers that hinder them from accessing quality healthcare. They are often thought to be a sign of curse or punishment from God and are seen as a source of shame. As a result, some have been abused, killed, abandoned, insulted, isolated, and excluded.⁶

The Prioritizing GESI Across Health Interventions project in Western Equatoria sought to reach vulnerable groups such as adolescent girls, persons with disabilities, people living in remote areas, those living in poverty, informal sector workers and the elderly poor, people living with HIV/AIDS, commercial sex workers, prisoners, IDP's and refugees.

OBJECTIVES OF THE PROJECT

The overall goal of this specific component of the Health Pooled Fund project is to address gender equality and social inclusion issues within the health service delivery in Western Equatoria.


The objectives were to:

- 1 Create a conducive environment for integration GESI in the health.
- 2 Build the capacity of health providers and ensure equal access to and use of health services by the poor, vulnerable and marginalized population.
- 3 Improve the health seeking behavior of the poor, vulnerable and marginalized populations so they can obtain health services based on their rights.

6 CARE. 2016. Inequality and Injustice: the deteriorating situation for women and girls South Sudan's war - A Progressive Gender Analysis: 2013 – 2016.

EVIDENCE OF IMPACT





World Vision considers GESI evidence of impact as transformational along five domains of access, participation, decision-making, systems, and well-being. Overall evidence suggests that Prioritizing GESI Across Health Interventions in Western Equatoria project increased access to health services for vulnerable populations. It strengthened the health system and supported the establishment of essential infrastructure in health facilities including building ramps for persons with disabilities and private rooms for delivery or the examination of survivors of SGBV. It helped increase the number of persons with disabilities accessing health services. It also enhanced access to services for survivors of SGBV, and persons with mental and neurological disorders.

THE STRUCTURE OF THE PROGRAM

The Health Pooled Fund project was organized in phases. **Phase one**, which was implemented for 3 years from 2013 -2016 focused on infrastructure development for health service delivery. **Phase two**, which was implemented from 2016 - 2019 focused on strengthening the capacity of the County Health Department to provide health care services. The major activities in phase two included training the county health department leaders, installation of internet, developing systems such as the human resource information system, the health information system, and electronic payroll systems, among others.

This documentation is focused on **phase three**, which is a five-year project (2019-2023) focused on stabilizing the healthcare system, in which Gender Equality and Social Inclusion is prioritized. GESI is a unique strategic goal that was not systematically considered in earlier phases of the project. Phase three is based on the comprehensive approach to GESI integration in recognition of the following principles:

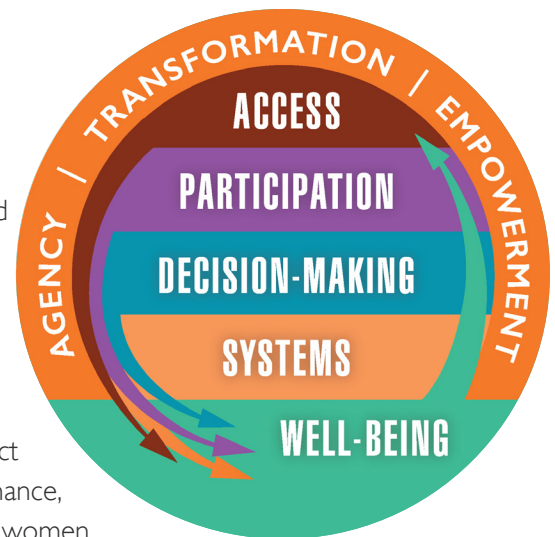
- That addressing gender inequality and social exclusion and developing effective responses/approaches requires engaging with women and girls, as well as men, boys, young people, older people, persons with disabilities including those with mental disabilities and people from different ethnicities and religions.
- That developing effective responses and approaches requires engaging with women and girls and other socially excluded persons and understanding the realities of their lives.
- That it is just as important to integrate women, girls and other excluded groups in more 'mainstream' interventions, as well as to support initiatives targeted specifically at bringing about changes in gender inequality and social exclusion.
- That gender equality and social inclusion issues are integral to program activities, and not just mere add-ons. This includes engaging with these issues at the early stage of project design, implementation of activities, and throughout all program processes, and allocating sufficient human and financial resources.

- That women, girls and other excluded groups experience access to health services, community engagement and oversight and accountability processes in different ways, and different aspects of exclusion and inequality should be understood equally.

Guided by these principles, World Vision South Sudan took a systems approach and worked in collaboration with the Government of South Sudan, Ministry of Health and county health departments. It partnered with key actors, including UNICEF, WHO, UNIFPA and the Catholic Diocese of Tambura Yambio, Boma⁷ (village) health initiative. The approach mobilized existing networks for action, working with diocesan health workers, facility health management committees, the Ministry of Health community health workers, the Ministry of Gender, Child and Social Welfare, the sexual and gender-based violence sub cluster in the region, the Disability Integration Coordination Forum, and the Mental Health and Psychosocial Support Technical Working Group. The project enhanced gender equality and social inclusion in the health systems along the five GESI domains.

ACCESS

The project improved access to quality health services particularly for survivors of Sexual and Gender-based Violence, pregnant and lactating women, children, and persons with disabilities. The total number of victims treated for both Lot 7 and 8 was 1097 in 2020 (784 females and 303 males). Among these, 53 were under five years of age (30 females and 23 males).⁸ The project provided basic dignity kits to survivors of rape or other SGBV incidents. These kits were made available at the health facilities, which also provided treatment and reconstruction resulting from SGBV injuries and physical harm, and ensured dignified menstrual health and hygiene management. The project created private spaces for women and girls through renovation, maintenance, and construction of maternity wards to make them more accessible for women and girls and to ensure confidentiality and privacy during examination of expectant mothers and SGBV survivors. This had a positive impact on the number of patient's attendance at the health facilities. Thus far, the renovation work has been done in the health facilities in Naangbimo, Mangmondo and Yabua and in 2020 there was nearly a two- fold increase in the number of births now occurring at these health facilities, from the baseline in 2019.



The project improved access to services for maternal and child health, including safe motherhood and sexual and reproductive health. The project installed solar power in all the supported health facilities for night deliveries and constructed health facility staff quarters which housed the midwives to be able to provide ongoing child-birth services, night, and day. The project enrolled, trained, and registered skilled midwives, who provided safe deliveries and care, and conducted health awareness campaigns. There was an increase in deliveries by skilled birth attendants by 53.8 % (3132 in 2019 to 4817 in 2020) and 58 % (4,361 in 2019 to 6,901 in 2020) for Lot 7 and 8 respectively. The program improved access to reproductive health education and resources to young women and adolescent girls to help prevent early and teen pregnancy.

⁷ A Boma is a lowest-level administrative division.
⁸ HPF. 2021. HPF3 Year 2. Final Report Lot 7 and Lot 8.

The family health sessions conducted covered child health, family planning, nutrition, SGBV and other general health topics. More than four hundred thousand (413,851) community members were reached with health awareness sessions from April 2020 to March 2021 for both Lot 7 and 8. This represents an average over performance of more than 100 % (162 % and 80 % for lot 7 and 8 respectively).⁹

The program also provided psychosocial support services that fostered health seeking behaviors for women and girls. Within the health facilities, renovation, maintenance, and construction was done to create maternity wards and other private spaces for women and girls that ensured safe access and confidentiality during examination of expectant mothers and SGBV survivors. There was a significant increase in the proportion of children fully vaccinated against diphtheria, pertussis (whooping cough), and tetanus and the proportion of births attended by a skilled health worker. Unlike 2019 where measles was registered, no outbreak of vaccine preventable diseases occurred in 2020.

To ensure access to health facilities for persons with disabilities, the project modified them to include accessible infrastructure, ramps, and other accessible and safe spaces. Persons with disabilities were also provided with assistive devices including walking aids, wheelchairs, and tricycles to enable their physical access to the health facilities. The project ensured ease of access to the health facilities buildings and washrooms. Accessible latrines were constructed with ramps, and this increased latrine access from that below 50 % to 100 % in all the supported health facilities. The latrines were specific to males and females and equipped with accessible internal locks that made them convenient and safe for women and girls. The total number of persons with disabilities in both Lot 7 and 8 that accessed health services increased from 1,639 in 2019 to 15,069 in 2020. The use of the disability assessment tool (Washington Group Short Set Questions) helped to identify the persons with disabilities and differentiate their needs. Before this initiative, many persons with disabilities had not been identified, and they had limited access to health facilities.

A young girl with disability articulated how a tricycle helped her to gain access to not only health services, but to other community spaces. She said: “I used to be confined at home but now I can move and feel that I am part of the community. I will also use tri-cycle to access healthcare whenever I fall sick.”¹⁰

To further support people with mental health illness seeking health services, a total of 74 health facilities trained their staff on how to effectively identify and manage mental health illnesses. As reported during one of the hospital advisory board meetings by the chairperson and community representative, “The service delivery has improved, and more people are now accessing the services. There are qualified staff, and the health facilities are well organized. There are no more delays like before. There is power (solar energy) and service delivery is ongoing 24/7. All these have attracted more persons to access the services.”

9 HPF, 2021. HPF3 Year 2 Final Report Lot 7 and Lot 8.

10 World Vision South Sudan, 2020. Gender and Social Inclusion Programs.

PARTICIPATION

The project applied an inclusive and participatory design, which included consultative dialogues with core participants during the design phase, including community leaders, religious leaders, women and women's organizations and networks, youth and their groups, and persons with disabilities. Representatives from each of these groups were given a chance to air out their views on how health service delivery could be improved to meet their needs and those of other vulnerable groups.

To promote women's participation and strengthen their leadership skills and involvement in running the affairs of the health facilities across Western Equatoria, the project established Health Management Committees at the village and boma level (the lowest-level administrative division, below payams¹¹). These committees were mandated to include women's meaningful participation in monthly meetings and to ensure women chaired or co-chaired meeting sessions, and had a voice in important decisions that were being made. The project prioritized and recruited women to ensure their participation, including in leadership and governance. At the beginning of project implementation, most women were excluded from leadership positions in the health system, and most decisions were made by men. All key community structures in Western Equatoria – such as hospital advisory boards, health facility management committees, and community health worker positions – were dominated by men. But by 2020, the project had female chairs/co-chairs in the Boma Village Health Committees. Women engagement as chairpersons or co-chairs positively strengthened their leadership skills and participation in decision-making. The sensitization campaigns helped to empower women to participate in leadership positions and engage in various community affairs. To date, women occupy 40 % of the boma health worker positions, which is a salaried position. Additionally, women occupy 50 % of health unit management committees and 50 % of the Boma health committees which are voluntary positions in Yambio and Nzara counties. This improved the overall involvement of women in running the affairs of the health facilities.

Also, with the establishment of a full gender equality and social inclusion department within the project, there was a significant increase of women's recruitment, and the opening of spaces where women were able to participate and take on leadership positions. The gender equality and social inclusion department ensured women were selected into leadership positions at the Health Facility Management Committees and that persons with disabilities were provided with opportunities and assistive devices such as tricycles and walking aids to facilitate their participation. Several interventions were put in place to enhance the capacity of health workers to effectively address gender equality and social inclusion issues within the health service delivery. These included provision of treatment guidelines to health workers, consistent support, and supervision, on the job coaching, mentorship by the project staff, and attendance monitoring in all the supported health facilities.

11 A Payam is the second-lowest administrative division.

DECISION-MAKING

The program increased women's ability to make decision in nearly 75 health facility committees, as already suggested under the participation domain. Women leaders influenced and made decision relating to issues such as accommodating the privacy of women receiving antenatal care, protecting SGBV survivors, ensuring that lighting at the healthcare facilities was prioritized to facilitate night deliveries or SGBV care, and ensuring that security and safe housing was provided to female health workers (such as nurses and midwives) or those seeking health services at night. In addition, the implementation of the health education interventions and the engagement of male champions contributed to general acceptance of women's decisions and improved women's ability to make key decisions about their lives and health. There was an increase in women's ability to make decision around family planning, child spacing, attending antenatal services regularly, making life saving decisions for emergency obstetric care, and/or delivery at health facilities without seeking permission from their husbands. A midwife from one of the Primary Health Care Centre said:

“Nowadays, we are able to give women contraceptives independently even without the consent or accompaniment of their spouses. The men on the other hand no longer reject family planning because they have understood its importance.”

Women and persons with disabilities who held leadership positions made and influenced all important decisions that were made by health management committees both at the Boma village levels, and at the unit levels. These included decisions that were considered non-traditional for women or persons with disabilities, such as infrastructure and physical renovation of health facilities.

SYSTEMS

The program implemented one-stop centers and a referral system on sexual and gender-based violence, linked to the health facilities at the community level. The referral system was also linked to the sexual and gender-based violence committees that were established in each community at the payam level (the district level below counties) and trained on the referral pathways and health system strengthening. The referral pathways enhanced reporting and SGBV service provision.

The program also established a network of trained, skilled, enrolled, and registered midwives, in accordance with World Health Organization (WHO) recommendations to improve maternal and infant mortality and address Sustainable Development Goals (SDGs) targets. Another system that the project established was a coordination mechanism with the Government of South Sudan and a strengthened

health systems and facilities to meet the needs of the most vulnerable, including women, children, and persons with disabilities. The project established a full GESI department with a goal of providing training for project staff, county health department staff and health workers on gender integration; and to significantly increase women's participation and the number of women in leadership positions. The GESI department was led by a GESI Coordinator, in collaboration with 5 social workers and 20 GESI focal persons. The project appointed a Project Director and Project Managers to provide technical oversight of the project and ensure the design a gender transformative and inclusive design. The Project Coordinators, specifically the GESI Coordinator, supported GESI integration and project leadership on GESI integration and GESI specific activities. Overall, the project strengthened the health system, making it more equitable and inclusive for women, children, persons with disabilities, and other vulnerable groups.

WELL-BEING

One of the priority areas of well-being that this project addressed was prevention and protection from sexual and gender-based violence. In addition to providing access to services for survivors and establishing systems for referral and reporting, the project implemented survivor-centered and community-led interventions to enhance their safety and dignity of victims. Interventions included the establishment of safe and friendly spaces for survivors, the provision of dignity kits, and the support for dignified menstrual hygiene management for survivors of rape or other forms of sexual and gender-based violence. The project also engaged community leaders and male champion groups to enlighten the communities about the negative impacts of sexual and gender-based violence on survivors and on entire families and communities. These men facilitated community dialogues and SGBV awareness raising campaigns. The gender-based violence committees established consisted of both females and males, and formed a link between the community and the health facilities. They engaged in constant identification of SGBV cases and linked the survivors to health facilities for care. The committees were also used as entry points to the community whenever there were awareness efforts related to sexual and gender-based violence. In addition to the trainings on referral pathways already discussed in preceding sections, the committees were trained on several topics such as the essence of obtaining treatment within 72 hours of sexual assault incidence, forms of sexual and gender-based violence, services available for survivors and how to access them, how to report a sexual assault incidence, health risks and community approaches to preventing sexual and gender-based violence. These interventions helped to increase understanding on the inviolable rights and dignity of women and girls. During the community feedback sessions, one of the Boma health workers said:

“We no longer witness so many cases of domestic violence compared to the past. I believe the men are getting to understand the need to treat women with dignity and avoid gender-based violence.”

The project conducted monthly awareness and sensitization sessions on sexual and gender-based violence. The goal was to increase awareness on SGBV root causes, forms, consequences, prevention and how to respond to it. These sessions were done through airing of live radio talk shows, or previously recorded radio spot messages, conducting community dialogues, or conducting routine gender-responsive and inclusive health talks during health education and integrated outreach programs. Education, information and communications materials on gender and social determinants of health, and on specific topics such as sexual and gender-based violence were developed and distributed. The awareness campaigns and sensitization programs served as a means for advocacy for the broader support for gender equality and social inclusion to break the traditional gender roles of women in most of the communities.

The increased access for persons with disability already discussed under the access domain resulted in greater well-being. Persons with disability who gained access to devices reported feelings of worthiness and being valued. A 28-year-old participant in Yambio county who spent 3 years without a wheelchair said:

“It just feels good to know that there are organizations that remember people like us. I feel valued and excited that there are people who still see us as human beings, and important in the society.”

A 19 years old girl with disability reflected on her feelings of increased physical and psychosocial well-being. She said, “I have been suffering without a tricycle for the last 9 years. As you can see, I have wounds on my legs because of crawling on the ground. I was helpless but thanks be to World Vision’s project for saving my life. I will use this tricycle to go to church to thank God who saw my suffering and provided miraculously. I will also use it to move to social gatherings and identify with other people in a decent manner.”¹²



LESSONS LEARNED & RECOMMENDATIONS

The Prioritizing GESI Across Health Interventions in Western Equatoria project strengthened health systems and facilities, increased awareness on health issues, and capacity, transformed social norms, and created an enabling environment toward the advancement of gender equality and social inclusion in each of the five GESI domains. Key lessons learned and recommendations include the following.

GESI ASSESSMENTS

For better GESI integration, there is a need to utilize data from GESI assessments and analyses on gaps, barriers, and opportunities. The GESI assessment would have been useful in assessing staff core competencies to allow for targeted staff capacity development through training, mentorship, and technical support for GESI integration at all levels—design, monitoring, and evaluation. It would also have helped in targeted health service delivery by specialized human resources. A gender equality and social inclusion health system offers special services for vulnerable populations, such as sexual and gender-based violence services and treatment, mental health support, psychiatric treatment, translations, or other assistance for persons with disabilities like those hard of hearing, and so on. It is important to develop context-specific approaches that address harmful social norms and create an awareness and foster an enabling environment for the participation of women, girls, persons with disabilities, and other vulnerable groups in health-systems leadership and governance. GESI training should also be conducted based on the need and gaps identified from the GESI analysis. The project utilized such GESI analysis to provide gender training to the female members of the Health Facility Management Committee, who were then able to identify gaps in service delivery based on the needs of the most vulnerable. This resulted in interventions such as the installation of solar light and energy to aid skilled birth deliveries and rape treatment at the health facilities at night or with the darkness of dawn.

MULTI-STAKEHOLDER ENGAGEMENT

The project successfully engaged different stakeholders including the Government of South Sudan, donors, faith-based actors, and community partners, which created opportunities for advocacy and external engagement on GESI transformative activities. It also resulted in consistent communication with the state's Ministry of Health and Ministry of Gender, the County Health Departments, local government structures and the community. Each stakeholder had a specific roles:

Stakeholder	Roles
LOCAL LEVEL	
Catholic Diocese of Tambura Yambio	Implementing partner in Nzara County
Boma Health Initiative Workers	Created demand for health services in the community
Facility Health Management Committees	Responsible for management of the health facilities
STATE AND NATIONAL LEVEL	
State Ministry of Health	Supported and coordinated health partners in the state
State Ministry of Gender, Child, and Social Welfare	Supported and coordinated protection and education partners in the state
DONOR AND OTHER KEY STAKEHOLDERS	
Health Pooled Fund donors: United Kingdom Government, the Government of Canada, the Swedish International Development and Cooperation Agency (SIDA), United States Agency for International Development (USAID)	Provided the funding for GESI activities
Sexual and Gender-Based Violence Sub Cluster and partners	Coordinated humanitarian response to sexual and gender-based violence and collaborated across all stakeholders and partners on prevention, protection, and response.
Disability Integration Coordination Forum	Coordinated and supported activities related to disability integration
Mental Health and Psychosocial Support (MHPSS) Technical Working Group	Coordinated activities of mental health and psychosocial support and offered such services to affected persons

REPLICABILITY

The program has demonstrated successful replicability in that it has been implemented in five (5) counties and in seventy-four (74) health facilities in Western Equatoria State. Since the program has successfully strengthened health systems and delivered essential health services across eight of the South-Sudan previous ten states (23 of the 32 new states), there is great potential for further replication of this promising practice beyond Western Equatoria State.

SUSTAINABILITY

The project applied a multi-sectoral approach, working with diverse partners and the Government of South Sudan to enhance their capacity in integrating gender equality and social inclusion in health systems. The networks of trained health workers and volunteers, such as registered nurses, sexual and gender-based violence prevention committees, male champions, and health management committees that were established and integrated into health facilities and community structures can be sustained beyond the project cycle. These volunteers and health workers will continue to play a critical role in ensuring that gender equality and social inclusion is incorporated in their routine activities in the community.

Additionally, the training of the County Health Departments on GESI helped incorporate GESI capacity in health staffing that will be utilized in ongoing GESI integration projects. For example, the staffing of County Health Departments in 2019 was 100 males. However, after the training, females occupied leadership positions within the county health department which is the leading government body in health care service delivery. For example, Yambio and Nzara country recruited female administrative and HR officers. This approach to have GESI-responsive hiring practices can be sustained.

FAITH-BASED APPROACH

The implementation of this project was done in consortium with the Catholic Diocese of Yambio and Tambura (CDTY) which has a wide network of churches and religious leaders. In Western Equatoria, CDTY has the largest Christian base, and is generally respected by the entire community. World Vision leveraged the CDTY's social capital to mobilize and share gender equality and social inclusion health messages to the people of Western Equatoria. The wide network of churches and its leaders was a great resource utilized by the project to raise awareness and engage congregations. Additionally, CDTY utilized its faith-based radio station to conduct radio talk shows and air out radio messages. Furthermore, through partnership with faith-based organizations, the project used church premises as centers for community dialogue on matters related to inclusive health systems strengthening and sexual and gender-based violence awareness, prevention, and protection services. The project also engaged Faith leaders to pass on health messages during religious services and other social gatherings.

IMPLEMENTATION IN FRAGILE CONTEXT

South Sudan has experienced significant levels of fragility, conflict, and violence for more than four decades. This has caused erosion of most of the physical and social infrastructure, and resulted in death and displacement of millions of people. It is estimated that more than 400,000 lives have been lost since 2013 due to conflicts, and millions more have been displaced.¹³ Despite gaining independence in 2011, South Sudan continues to be ranked among the most fragile states globally. The health indicators are among the worst in the world – including high maternal mortality, infant mortality, and under five mortality rates. Within this fragile context, the country's health needs are vast, and there are high levels of poverty. In this regard, this project has demonstrated success in addressing fragility through the implementation of community-based and participatory activities that actively engaged with transforming gender inequality and social exclusion in the long term.

COVID-19 IMPACTS

The COVID-19 pandemic negatively affected the implementation of project activities in so many ways. For example, some of the frontline health workers got infected with COVID-19. This caused staff shortages at the health facilities during the time of their isolation and treatment. In response to the COVID-19 outbreak, many health workers faced heavy additional workloads, long working hours, and a lack of enough time to rest. There were shortages of essential supplies for infection prevention and control. There was a strain on the existing resources because there was an urgent need to procure personal protective equipment for COVID-19. The regular supplies ran out because of the rapid increase in the need for handwashing facilities, sanitizers, gloves, masks, and others.

The government ordered lockdown and restricted movements, gathering, and public congregations that made it hard to implement some activities. For example, trainings and social events such as community dialogues had to be postponed.

World Vision South Sudan ensured that guidelines from the Ministry of Health and WHO to prevent the spread of COVID-19, were followed. These included COVID-19 screening at all the supported health facilities, provision of Infection Prevention and Control (IPC) materials, additional benches to allow social distancing, providing additional handwashing facilities, and mandating the wearing of masks. As part of the response, the project provided training to health care workers on COVID-19 preparedness and response screening at the Western Equatoria health facilities.

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