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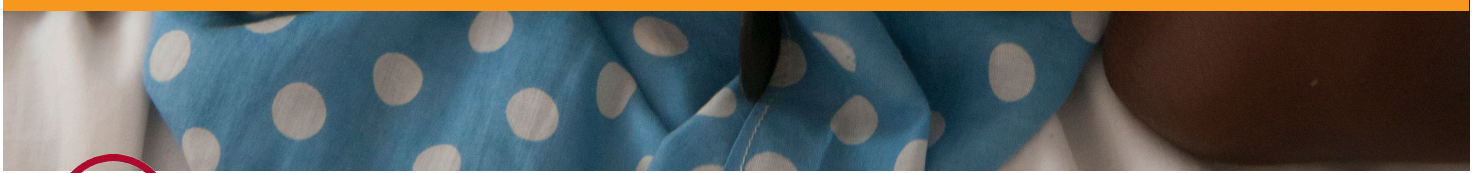
DEVELOPING NURSES/MIDWIVES EDUCATION IN SOUTH SUDAN – A PRE STUDY

By Bodil Tveit, Odd Evjen, Lucia Buyanca, Haldis Kårstad



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PRE-AMBLE **Primo March 2014**

This study was conducted during the period of September to November 2013. During the process of finalizing the report the situation in South Sudan changed dramatically in mid December 2013 resulting in a scenario of prolonged conflict at the time of the finalization of this report in early March 2014.

The conflict has resulted in a serious political, economic, social and humanitarian crisis with a deep divide within the existing political governance of the nation, an increasingly divided nation along ethnic fault lines, threats of reduced national income as well a dramatic humanitarian consequence.

The crisis necessitates recalibration of priorities both within the Government of the Republic of South Sudan as well as the international support to South Sudan. This development poses distinct challenges to all dimensions of analysis within this report...

However the current crisis does not in our opinion change or undermine the key analysis and recommendations of the report significantly. On the contrary the effects of the crisis underline in our opinion the need for increased attention to the key strategic concerns forming the background for the analysis and subsequent recommendations. The crisis in South Sudan may lead to a situation where international donor capacity and prioritization stand the risk of domination of short term needs of escalated humanitarian assistance. The need for recovery, long term development priorities and commitment is even stronger in areas where this is possible within the unfolding scenarios. The recommendations for investment in nurses/midwife training in this report place themselves in the nexus of at least three strategic concerns that may be perceived as vulnerable and subject to possible deterioration within this context ; (i) global high maternal mortality rates that may be assumed to increase within a sustained humanitarian crisis scenario (ii) the global low levels of girls education and the gender disparity gap in higher education may be further negatively impacted and (iii) the need to develop South Sudanese national capacity as a key element in nation building in a renewed post crisis environment may be overrun by short term concerns for quick impact through reliance on external capacity. In addition the recommendations contribute to implementation of key governmental policy frameworks within health and education as well as towards bridging the center-periphery divide through investing in regionally based capacity development.

The geographical location of the recommended key initiatives within South Sudan are all at time of writing within areas that are able to sustain long term development initiatives both in regards to governmental as well as national church partners related capacities.

In our view the unfolding events further underline the need for investment in health capacity education which in a significant way addresses the needs of women and girls who are taking the brunt of the consequence of the crisis. As such the ideas and recommendations of report offers an option for an investment in a time of crisis that can harvest significant benefits for the many women and girls who have no say in the current crisis but who carry the future of the nation within them.

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Executive summary

The study was carried out as a pre-study to explore the possibilities for NCA, South Sudan, to develop a capacity building project to improve health education in South Sudan. This executive summary goes over the main results of the assessment regarding the following assessment areas:

Policies and government structures

The government structures in charge of the policy of education of nurses and midwives in South Sudan are still not fully at place. One important weakness is **the absence of a regulatory body** for nurses and midwives. In the absence of such structures, the regulation appears to be difficult and the dialogue between key stakeholders involved seems to be random and unsystematic. One of the most problematic aspects with the current policy is linked to the skill mix plans for nurses/midwives where the policy seem ambivalent and may be too much focused on the higher cadres of nurses/midwives (diploma levels) while more emphasis on the lower cadres (enrolled levels) seem to be more suitable to meet the countries need in the current situation. The current establishment of a **professional association for nurses and midwives** is an important step in the right direction. The challenge is now to further implement these structures and sensitize nurses and midwives to actively take part in the development and maturation of them.

Existing pre-service education for Nurse/ Midwifery cadres

There are existing educational institutions for training of nurses/midwives in all states of South Sudan. The condition and state of these institutions regarding infrastructure is though very divers and some institutions have an extremely low quality. Both lack of adequate infrastructure and poor quality of teaching are important problems. The standardized new curriculums have apparently weaknesses and are not always adapted to realities on the ground. A significant problem in all the institutions (at least outside Juba) seems to be the quality of the clinical training since there is a severe shortage of trained health professionals at all levels in South Sudan. Another problem is tutors. Currently there are not very many qualified South Sudanese nurse/midwife tutors. Most of the tutors are recruited from outside South Sudan mainly from Kenya, Uganda and other neighboring African countries and are on short contracts which create an unstable situation for the training institutions. The plans for building up a South Sudanese tutor group seem not very advanced.

Relevant stakeholders' roles related to training of nurses/midwives

A patchwork of actors is involved in training of nurses and midwives in South Sudan. The efforts, often from NGOs, CBOs and international partners, to be able to fill gaps and solve immediate problems may sometimes compromise more sustainable solutions. There is also a lack of coordination of all the partners involved in education of nurses/midwives both at national level and at state level. The existing coordination mechanisms in the health care sector such as a) the Health Clusters at national and state level, b) the Health Clusters at national and state level and c) the NGO–Forums, are all focusing on coordination of activities related to health service delivery and not on capacity development and education.

General problems influencing the area of nurse/midwife education

The poor status and image of nurses and midwives within the population of the country represents a particular problem. The problem of status may be linked to the history of South Sudan since many of the nurses and midwives working in the countries health facilities during the period of civil war were illiterate. One example is the frequent practice of employing traditional birth attendants in the midwife positions in the health facilities. Both recruitment and retention of nurses and midwifes are likely to be long-lasting challenges. Today quite a few students tend to use nursing education as a **stepping stone** for further studies (medical studies, other university degrees) and are not really interested in nursing/midwifery as such. **Gender** is another very important area related to education of nurses and midwives in South Sudan. The recruitment of many male students in to nurse/midwife education lately can be looked upon as a resource, but there are also possible problems linked to the entrance of male into the nurse/midwifery-profession. One example identified in the interviews was a lack of respect for female tutors and female students shown by male students, many of them former soldiers.

Key recommendations

Based on the findings and the discussion the assessment group recommends that NCA does not duplicate the national level approach as in Malawi but rather builds on the experiences from Malawi and transform/adapt them to design a dual state approach through;

1. Support the establishment and development of a MOH owned and run nurses/midwife training institution in Eastern Equatoria using Torit Hospital as a base and the existing church and government health facilities as recruitment bases and satellites for practical training

2. Support the continued expansion of nurses/ midwife training in Wau through the existing Catholic Church training institutions to include recruitment from Warrap state health facilities. This support would need to be aligned with continued sustainable support from CIDA/UNFPA to the existing state run midwife training college in Wau.

3. Contextualize experience gained from the Malawi program into programmatic support in South Sudan for nurses/midwife training with a focus on infrastructure development, capacity building of educators, capacity building of management, strengthening professional organizations, facilitation of collaboration and between stakeholders involved and link peer to peer collaboration between Norwegian and South Sudanese nurses/midwife institutions and professional organizations

.The added value for NCA in this is the ability to translate acquired knowledge and trust into an approach which facilitates linkages between communities and health actors at all levels. Building on the long lasting involvement in South Sudan and the high level of trust achieved through the years, NCA has the potential to create a model approach in the two states that could be a significant contribution towards the building of a stronger health workforce in the new nation of South Sudan.

Acronyms

AAH-I	**Action Africa Help - International**
AMREF	**African Medical and Relief Foundation**
ANC	**Antenatal Care**
CDC	**Center for Disease Control and Prevention**
CDOT	**Catholic Diocese of Torit**
CHD	**County Health Department**
CHTI	**Catholic Health Training Institute**
CHW	**Community Health Workers**
CIDA	**Canadian International Development Agency**
CMW	**Community Midwife**
CPA	**Comprehensive Peace Agreement**
CPD	**Continuous Professional Development**
DFID	**Department for International Development (UK)**
GRSS	**Government of South Sudan**
HPF	**Health Pool Fund**
ICM	**International Confederation of Midwives**
IMC	**International Medical Corps**
IUNV	**International United Nations Volunteers**
JCONAM	**Juba College of Nursing and Midwifery**
JDT	**Joint Donor Team**
NCA	**Norwegian Church Aid**
NGO	**Non-Governmental Organization**
NPA	**Norwegian Peoples Aid**
PEPFAR	**President's Emergency Plan for AID Relief**
PHCC	**Primary Health Care Centre**
PHCU	**Primary Health Care Unit**
PRDA	**Presbyterian Aid and Development Agency**
SOMOSS	**Society of Midwives in South Sudan**
SPLA	**Sudan People Liberation Army**
SPLM	**Sudan People Liberation Movement**
SSANAMA	**South Sudan Nurses and Midwives Association**
SSCCSE	**Southern Sudan Centre for Census, Statistics and Evaluation**
TBA	**Traditional Birth Attendant**
UNDP	**United Nations Development Programme**
UNDPF	**United Nations Development Programme Funds**
UNFPA	**United Nations Population Funds**
WHO	**World Health Organization**

INTRODUCTION/BACKGROUND

1.1 Introduction

Two years into its life as independent nation South Sudan is facing many challenges. One of the most pertinent and demanding tasks is linked to the development of a sustainable health service delivery system for the population of South Sudan. The presence of an adequately trained health personnel work force is critical for the nation to be able to address the needs of the population. The current investigation focuses on the situation in the area of education of nurses and midwives in South Sudan. A group of four people consistent of the following persons were asked to undertake the assessment:

- Haldis Kårstad, Senior Advisor Health, Norwegian Church Aid, Oslo, Norway
- Odd Evjen, Senior Advisor, Norwegian Church Aid, Oslo, Norway
- Lucia Buyanca, Independent consultant, RNM, BSc, Kenya/ South Sudan
- Bodil Tveit, Associate Professor, RN, MHSc, PhD, Diakonhjemmet University College, Oslo, Norway

The overall goal of the assessment was to explore the possibilities for NCA South Sudan to develop a capacity building project to improve health education in South Sudan.

1.2 Context of nursing and midwifery in South Sudan

Now South Sudan is slowly emerging from over 20 years of civil war and decades of political and social instability before the civil war. The people of South Sudan are among the worlds' poorest, with 51% of the population below the poverty line. The total population of South Sudan is around 11 million (CIA, July 2013 est.) scattered over ten states covering about 640 000 square kilometers. More than 80 % of the population lives in rural areas often with poorly developed infrastructure in terms of roads and health facilities.

One of the most alarming results of years of conflict can be found in the countries extremely poor health indicators. According to the available figures, the maternal mortality ratio in South Sudan is among the poorest in the world, 2 054 per 100 000 live births, about 90 % of deliveries occur in the rural areas and only about 10% of them occur in the presence of a midwife or person with midwifery skills. The infant mortality rate is 84 deaths per 1000 live births and the under-five mortality rate is 106. Only 2011, 40% of the population of Southern Sudan had access to primary health care (PHC) services. About 3, 1 % of the population is infected by HIV (SSCCSE 2011, WHO 2013). Also the general level of education is very low in South Sudan, as only around 27 % of the population over 15 years can read, 40 % of the male and 16 % of the female population, CIA 2009).

The situation is further challenged by the vulnerability of the South Sudanese economy as oil revenues constitute more than 98% of the Government of South Sudan's (GRSS) budget. With the shutdown of oil production in most of 2012 till mid-2013 and with new shut downs later in 2013, the subsequent government-imposed austerity measures have serious implications for the service sectors, including health. The national budget for the year 2012/2013 allowed for only 2.9% of the national budget funding to the health sector. The proportion destined for health in the budget of 2013-2014 is probably even below that. At the same time about 60-70% of the national budget is destined for security and

public service purposes. The health sector has been nearly totally reliant on external funding. An estimated 70% of health services are still provided by NGOs. Throughout the war and also after the CPA, the churches constitute important actors in the delivery of health services alongside the international contribution through NGOs. A key challenge rests with the government's ability and commitment to take the responsibility for implementation of the respective policies governing the health sector development through increased allocation of financial and human resources.

1.3 NCA history and presence in South Sudan

Norwegian Church Aid has worked in Southern Sudan since 1972. A specific trait of NCA, emerging out of more than 40 years of presence, is long term commitment offering solid understanding of local context as well as relation building coupled with flexibility to adapt rapidly to changing circumstance. The communities, the church partners, the CBOs and the government structures express deep trust towards NCA as it never left; it was there pre-war, during the war and after the war and throughout it remained close to the communities.

The pre-war program (1972-1985) was primarily based on emergency delivery but soon developed into a rural development program seeking to contribute to the peace dividend for the people of Eastern Equatoria in particular. At its peak the engagement had evolved into a comprehensive multisectorial program which included health, education, agriculture, farmer's cooperatives and road construction. A highlighted result from this period could be termed as the cadre of well-educated Sudanese professionals who today constitute a significant contribution in both government, UN, INGO and church institutions. A *major learning* from this period was the need to focus on capacity development of both local organizations as well as local government. A *challenge* inherited from the pre-war period remains in the high expectations of the population, the partners and the government structures of NCA returning in the mode of intensive operational profile of the 1980's.

During the war-time (1985-2005) NCA worked on both sides of the conflict under the umbrella of Operation Lifeline Sudan (OLS) with bases in Juba and Khartoum for accessing Government of Sudan held territories as well as in Nairobi working within the SPLA held territories. The prime objective was to serve the population regardless of authority of the day. The strategy of "*working with, working through and contributing to*" was adopted as much as possible into the emergency scene blending own operationally and partnership specifically with the church network which had access beyond the reach of the external community. Working with and through the church structures in delivery of basic health services was a key component. In 1998 saw the inclusion of what is now Warrap State into the programmed in addition to the existing focus on Eastern Equatoria. During this period a *highlighted result* gained was the deep involvement that emerged on peace and advocacy with support to processes both within the south-south as well as the north-south divide primarily through the church networks.

During the CPA period (2005-2011) the program continued largely on a service delivery mode within education, health and food security seeking again to contribute towards the

peace dividend. In 2003 NCA made a policy decision to merge the South Sudan programmed into one base out of Juba. The churches, having been NCA's traditional partners from the war time period, experienced difficult times in light of the changing dynamics as their existing capacity and valuable experience was tapped both by the needs of capacity for increased INGO and UN presence as well the rightful emerging capacity needs of the governance structures. The NCA partnership strategy came under strain during this period as the need for reasons of the above merged with the need for upholding a strong service delivery chain to the population in dire need of assistance as the CPA also opened the gates for return of their fellow citizens who returned after being in internal or external exile during the war. A *key learning* emerging from this period remains as firsthand experience of the difficulties of transition from a conflict to post conflict situation in balancing the needs based and rights based approaches coupled with the of balancing the ideals of partnership and local capacity development with the operational mode often adopted to effectively secure the basic needs of the struggling population.

The post independence period (2011-to date) has focused on a strategy of *"capacity development for active citizenship"*. The primary geographic focus of the program has been Eastern Equatoria and Warrap states with supplementary focus on the emerging needs of Jonglei state as well as support to issue based advocacy at state and national level. While recognizing that within a context of a fragile state it will take time to build governmental capacity the existing service delivery of churches and NGOs are a lifeline of hope to a struggling population. For this reason the major thrust of the program has been geared towards a dual strategic entry of *capacity development* of local government and line ministry functions combined with a continued support to delivery of basic services (Health&WASH) at local level through church and local government actors. Developing capacity of partner churches and local government in aligning to governmental policies and standards within service delivery sector programs has been a key element in this approach. The vital elements of women's participation and strengthening of civil society capacity for advocacy at local and national level is seen as a contribution to the implementation of key policies and aspirations of the new nation of South Sudan.

A key result of the NCA supported health programs through 40 years in South Sudan is that they have been critical in providing basic health services to marginalized populations through churches and local government. *Key learning's* from implementation of the health program during the post war and independence periods can be summarized as;

- The difficulty of maintaining an appropriate balance between continued quality service delivery and development of local capacity and ownership.
- The health needs in South Sudan cannot be adequately met by short term, localized, project specific and relief focused interventions. The widespread structural deficit can only be met by working on a systemic and long term basis and to scale up interventions from local projects to national policies.

1.4 NCA experiences from nursing education development in Malawi

The current pre-study builds on the background Norwegian Church Aid has from being engaged in capacity building on education of nurses/midwives in Malawi from November 2005 till today. Through the collaboration project in Malawi important experiences have been acquired and a purpose of this pre-study was to explore the possibility of using methodology and experiences from Malawi in South Sudan, certainly with necessary changes and amendments based on differences in context.

In Malawi the churches are important contributors both in health service delivery and in nurse/midwife pre-service education. Christian Health Association of Malawi (CHAM) is umbrella organization coordinating the diverse church-affiliated health activities in the country including 9 health training colleges. A particular scope of attention for NCA has been the CHAM-colleges in Malawi. One particular feature with CHAM is the fact that many of the CHAM institutions are located in rural areas. As a consequence CHAM has made the decision to focus mainly on a 3-year education of an associate nurse/midwife cadre, Nurse- Midwife Technician (NMT), with competencies designed for the needs of the communities and rural areas.

The project "Improved Health Training in Malawian Nursing Colleges" commenced in 2005 with an overall purpose of contributing towards the improvement of nursing and midwifery services in Malawi. The background for the project was an emergency situation in Malawi; In 2004 the MOH in Malawi described the country's Human Resource for Health situation as "near collapse". The number of trained health personnel was alarmingly low with a nurse to population ratio of 1:3500 in 2004. Poor capacity in the training institutions both regarding infrastructure, equipment and methodology was identified as key problems (HRH Country Profile Malawi 2010). From 2004-2009, a six year Human Resource Emergency Plan and a six years Emergency Pre-Service Training Plan was implemented with participation from several international partners through the so called Sector Wide Approach (SWAP).

Norwegian Church Aid, funded by the Royal Norwegian Embassy (RNE) in Malawi, decided to contribute in the emergency plan to upgrade the human resource for health and to reinforce pre-service training of nurses/midwives. A partnership model took form and the project partners constituted a total of 14 Malawian colleges, 6 Norwegian Nursing Colleges as well as professional associations in Malawi and Norway (National Organization of Nurses and Midwives in Malawi (NONM) and Norwegian Nurses Association (NNA). A close collaboration with key stakeholders in Malawi, such as MOH, Nurses and Midwives Council of Malawi and the University of Malawi, Kamuzu College of Nursing, has also been important in the approach of the project. The project has been running in the following phases each with their own specific objectives and focuses: phase 1 from 2005-2009, phase 2 from 2009-2012 and currently phase 3 from 2013-2015.

The project has focused on two main goals; a) developing infrastructure for the CHAM-colleges and b) building capacity and improving quality in the nurse midwife education in Malawi focusing mainly on the Nurse and Midwife Technicians Program

The infrastructure component: Improvements of the physical facilities of each of the 9 CHAM training Colleges has been a vital element of the "Improved Health Training in Malawian Nursing Colleges". During the years from 2005- 2012, more than 60 buildings such as hostels, classrooms, administration blocks, libraries, staff houses, etc. have been constructed and renovated. Furniture and other equipment have been funded. All the CHAM colleges have received new clinical skills labs. The issue of maintenance has been high on the agenda and staff has been trained to assure management and preservation of the infrastructure. The result is that all the colleges now have more and far better facilities. The new infrastructure contributes significantly to ensure that the colleges have a good learning and teaching environment and contributes also to attract and retain staff in rural/hard to reach areas.

The quality of training in the nursing colleges: The second stake of the project has been capacity building of tutors and the focus of improving the quality of the teaching in the colleges. The expansion of infrastructure made it possible to double the intake of students. The need to focus on training of tutors as well as building of institutional capacity was evident. Throughout the phases of the project a *stepwise methodology* has been developed based on the perceived needs in Malawi and always in close dialogue between both Norwegian and Malawian partners and stakeholders.

Phase 1 from 2005-2009: Initially an approach of gap-filling was used, where Norwegian tutors were teaching Malawian students in subjects such as ethics, gender, HR and mental health in collaboration with Malawian colleagues. This approach was seconded by a focus on curriculum development in the same areas and was gradually switched to a Trainer of Trainers (TOT) approach with workshops with Malawian and Norwegian teachers on identified themes such as professionalism, ethics, gender, human rights, teaching and learning methodology, student active methods and problem based learning etc.

Phase 2 from 2009-2012: A more global focus on curriculum development was initiated with a focus on curriculum implementation of both classroom teaching and clinical teaching. The classroom teaching part concentrated on development of course outlines, lesson plans, and assessment forms in addition to teaching and learning methodology. The clinical teaching part concentrated on skills lab methodology and clinical teaching methodologies addressing themes like, supervision, guidance, collaboration between college and clinic, assessment of clinical teaching, OSCE etc. In the last year of phase 2 the decision was made to focus on research-based-knowledge and knowledge-based-practice. A research-training for tutors was initiated based on a "learning by doing approach" focusing research themes linked to local contexts of nursing/midwife education. The results of this training were presented in several national arenas. The second phase of the project was concluded in 2012 with a large international conference in Lilongwe with almost 200 participants from many countries. The title of the conference was "*Nursing Education in Africa-Changes and Challenges*". The work presented was of high professional standard and among the presenters were Malawian students and teachers who had been with the project from the start.

Phase 3 from 2013-2015: The focus on information literacy and developing a research based education continues, with a collaboration on developing locally based research project focusing development of nursing/midwife education.

Management: Parallel with the focus on tutors training and guiding in management of the colleges has been a strong priority. This has led to better and more strategic planning for the colleges as well as a strengthen practical planning (such as master plans) and focus on management and leadership aspect such as staff appraisal, staff development, maintenance routines etc.

Training of librarians: Libraries and librarians are keys to educational institutions and a focus of the project has been to strengthen libraries at the colleges. The Liberians have got refresher courses and have been trained in how to procure teaching and learning materials. Over 4000 New textbooks have been purchased during the years. Computer rooms are now available for students at all colleges.

Strengthening professional organizations: Throughout the project period a close collaboration between the National Organization of Nurses of Malawi (NONM) and the Norwegian Nurses Organization (NNA) has been developed. The work method has been to work on human rights, patient and health worker rights. During the years more than 700 nurses and students have attended these workshops. This work will continue also in the third phase of the project.

Spin off effects: The approach and the years of collaboration have generated several spin off effects some of them intended and others more unexpected. One of the most interesting changes throughout the years is the level of engagement and participation from the college leadership. The first years were characterized by uncertainty and hesitant participation from the colleges. The attitude was merely a passive, recipients' attitude, probably due to a long tradition of weak influence. The colleges' participation has increased remarkably during the years and the initiatives and ideas coming from the colleges have augmented and a local ownership to problems as well as strategies and solutions has increased. The "empowerment" of the college staff members and the professional associations as well as the creation of yearly "National Stakeholder Meetings" where all partners interested in nursing/midwives education could meet and discuss has led to a much closer and better collaboration between stakeholders like academics, professional associations, Council of Nurses/Midwives, MOH and NGOs involved in nursing/midwife education.

A main success criterion for the project was that all the CHAM colleges had good potential for infrastructure expansion and that the primary/secondary education system is relatively good in Malawi. The collaboration with the Malawian government and other important stakeholders engaged in development of nurses and midwives education has been fruitful. Today we can see impact of these big efforts as there has been an increase of nursing students from 3,456 to 5,899 between 2004 and 2011. The nurse to population ratio has increased from 1:3500 in 2004 to 1:1400 in 2012. More nurses work in the health facilities and are able to counteract the bad health indicators in Malawi. One of

the consequences is that the maternal deaths have decreased from 984 in 2004 to 460 in 2012.

2. STUDY DESIGN AND METHODS

The pre-study took place in September 2013 and the purpose of the assessment was to inform Norwegian Church Aid on the status/process of development of health training institutions for nurses and midwives in South Sudan. The goal was to enable NCA South Sudan to make a good and reality based conclusion of whether they should or not involve in the elaboration of a project for improved health education in South Sudan Health Training Institutions, if possible, within 2014.

The study was carried out as a pre- study for project development and focused on mapping the current situation and assessing further possibilities for such a project.

2.1 Specific objectives for the study

- Get an overview of current policies in the area of nurse/midwife education at both national and state level
- Explore if South Sudan have, or plan to, establish a Nursing and Midwifery Regulatory Council and a nurse/midwife association.
- Get an overview over of all existing training institutions and further capacity in South Sudan.
- Visit and assess existing health training institutions in Juba in Central Equatoria, Torit in Eastern Equatoria and Wau in Western Bahr el Gazal.
- Explore relevant stakeholders role related to training of nurses/midwives donor organizations, NGOs and FBOs working in the field, as well as coordinating bodies like health clusters, etc.
- Explore funding opportunities for a possible Improved Health Training Program in South Sudan
- Write recommendations for further work with the project.

2.2 Study team

The team consisted of the following persons:

- Haldis Kårstad, Senior Advisor Health, Norwegian Church Aid, Oslo, Norway
- Odd Evjen, Senior Advisor, Norwegian Church Aid, Oslo, Norway
- Lucia Buyanca, Independent consultant, RNM, BSc, Kenya/ South Sudan
- Bodil Tveit, Associate Professor, RN, MHSc, PhD, Diakonhjemmet University College, Oslo, Norway

Lucia Buyanca has experience from nursing policy development in Kenya as well as from work as a Nurse Midwife. Bodil Tveit has a PhD in Nursing education, long experience as a nurse educator/nurse including extensive international experience. She participates in the project "Improved Health Training in Malawian Nursing Colleges" and coordinated the Norwegian contribution from 2010 – 2012.

The team was seconded by representatives of the NCA South Sudan program Ayen Aleu Yel, Madut Malual Wol, Victor Nawi, Moria Janet, Kasio Luka and Ramadhan James.

2.3 Study Framework- Data Collection Methods

Interviews with selected informants and desk reviews of central documents constituted the main sources of information. The interview guides/questionnaires developed included both quantitative and qualitative questions, although the main approach was

qualitative. The interview-guides were semi-structured allowing the interviewer to explore and follow up on interesting answers or ideas coming up during the interviews.

2.3.1 Assessment of policies and government structures that may affect institutional capacity

Methodology:

- Desk-review of relevant health policy and government documents
- Interviews with key persons in GRSS-MOH and State MOH, and other key stakeholders

Assessment areas:

- GRSS-MOHs role in education of nurses/midwives
- Policies in place – such as regulatory systems M&E systems, standardization, accreditation, payroll, plans for CPD, plans for training of faculty, recruitment and retention policies etc.
- State level (SMOH)
- County level (County health departments)

2.3.2. Assessment of relevant stakeholders' roles related to training of nurses/midwives

Methodology:

- Desk-review of relevant health policy and government documents
- Interviews with key persons in the following organizations:
- UNFPA, WHO, IMC, CIDA, MERLIN,
- CDOT, St. Mary's Hospital Link, Isle of Wight and Global Fund health system Strengthening Initiative.

Assessment areas:

- Sources of funding/donors involved in funding of nurse/midwife education
- NGO's role in nurse/midwife education
- NGO's and donor organizations experience of the role of MOH and the policies in the area of nursing/midwife education
- Collaboration/coordination of donors, NGO's and CBO's

2.3.3. Collect information about the existing pre-service education for Nurse/ Midwifery cadres in South Sudan

Methodology:

- Review of existing curriculums for relevant cadres and other relevant documents
- Direct observation at 5 sites : Juba College of Nursing and Midwifery (JCONAM), Juba, Central Equatoria, Mary Help Nursing School, Wau, Western Bahr el Gazal, Catholic Health Training Institute, Wau, Western Bahr el Gazal, Torit
- Semi-structured interviews with principals to get information about the institution and perceived needs

Assessment areas:

- Infrastructure
- Human resources (tutors)
- Students (intake – graduation- problems)
- Study program
- Experience of the role of MOH and the policies in the area of nursing/midwife education

3. FINDINGS

This chapter presents the findings based on the data collection described above. The chapter is arranged in six main sections matching the focal areas for the study. All sections use information collected both by desk reviews and interviews. However some sections have documents as their most important source of information while others are mainly informed by interviews with stakeholders, observations and other informal strategies during the field visits.

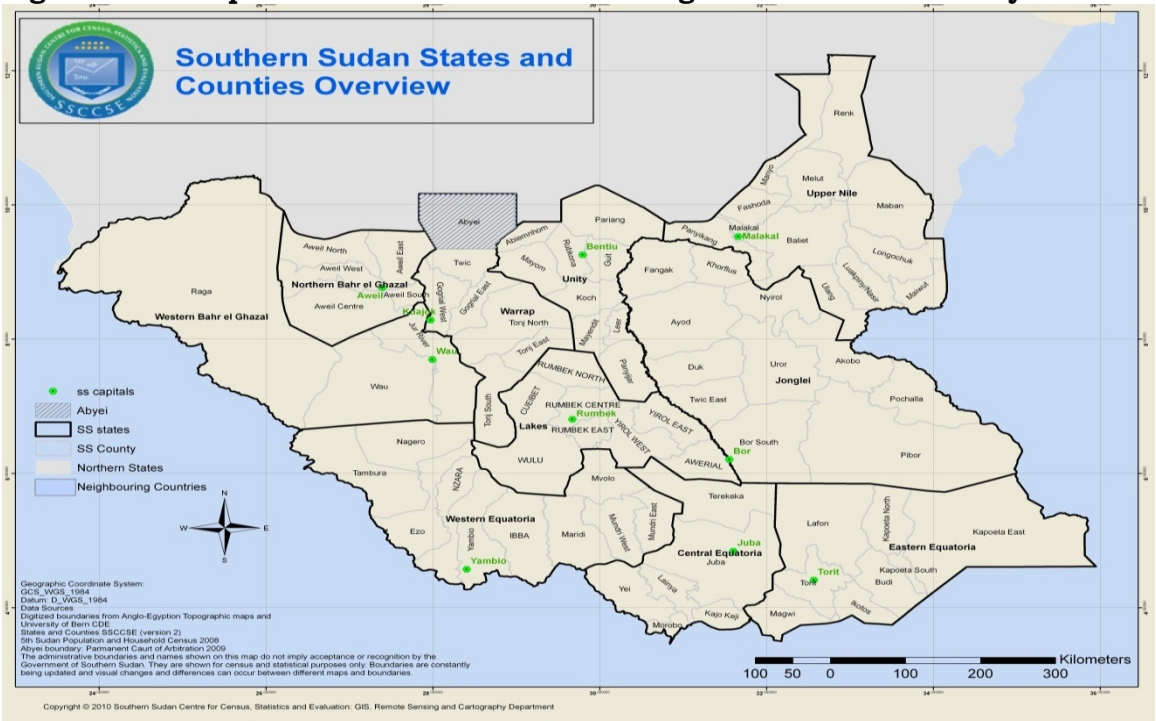
3.1 Policies and governance structures

This section will try to produce a picture of policies in the area of human resource for health, more specifically policies regarding education of nurses and midwives in South Sudan. The findings are based on both desk reviews (document analysis) and semi-structured interviews with relevant stakeholders conducted by the assessment team during the visit in South Sudan.

3.1.1 Health Governance through a decentralized structure

The government of South Sudan, through its Ministry of Health, has the main responsibility for the development of the health sector in South Sudan, including the Human Resource production and management. Yet, since the interim constitution of South Sudan (2005), a decentralized management structure has been adopted, and each of the 10 states in South Sudan has its own state MOH.

Figure 1: Map of South Sudan showing State and County boundaries

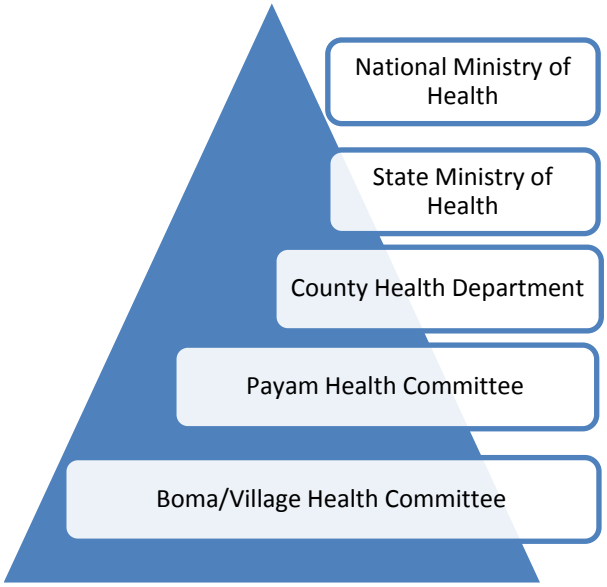


Source: *South Sudan Centre for Census, Statistics & Evaluation (SSCCSE, 2010)*

The GRSS-MOH is in charge of the health sector policy development, health financing and health sector partner coordination at country level. It manages the three teaching

hospitals (tertiary level- specialized care) and has a supportive role to the State Ministry of Health which in turn is in the lead of health service delivery and management at state level (secondary level – state hospitals and county hospitals). The ten states are further subdivided into 79 counties and each county has a County Health Department (CHD) responsible for the delivery of primary health care services mainly through Primary Health care Centers (PHCC) and Primary Health Care Units (PHCU). The CHD manage the delivery of PHC services at Payam level and Boma/Village level. The policies and strategies set by the states are derived from the national policies, but each state has discretionary freedom to decide their own priorities. At present MOH continues to perform some service delivery functions which are within the core function of SMOH, due to capacities inadequacy at SMOH level. Furthermore not all CHD are fully functioning either. Currently the health care sector is facing a huge financial deficit, weak structures, and a huge dependence of international donors as well as implementing NGOs. Less than 3 % of the national budget is used in the health sector, meaning that external partners such as NGOs and FBOs play an extremely important role in the health sector of South Sudan

The organisational and management structure



Source: Health Sector Development Plan 2012 – 2016 (GRSS-MOH 2012)

3.1.2 The Health Sector Development Plan 2012 – 2016

The 28th February 2012 the new Health Sector Development Plan (2012–2016) for South Sudan was launched. The plan reflects political ambitions to transform the current poorly structured and poorly functioning health system and improve the quality of health service delivery in South Sudan. The Health Sector Development Plan 2012-2016 depicts two factors that will be critical for achievements of health sector goals for the years to come:

- Adequate human resources for health

- Improved accessibility of health services for the population

A sustained focus over the next five years will, according to the plan, be placed on training, recruitment and motivation of an adequate number of the right skill mix of health personnel to work with the right support in service delivery of quality health services with a focus on women and children in rural and peri-urban communities.

Within the strategic actions described in the plan is to prioritize a substantial increase in training of midlevel cadres (clinical officers, nurses and midwives). It is also in the plan to standardize curricula, put in place an accreditation system and to renovate/construct infrastructure for training institutions as well as to recruit more tutors.

The plan provides a table of HRH gaps and projections of the need of HRH, including various cadres of nurses/midwives and auxiliary workers, as follows:

Table 1: Projections of the need of HRH

Priority Human resource for health	***2012 estimated baseline***	***2016 (MOH recommended staffing norms)***	***Number HRH to recruit(gaps based on basic needs)***
Registered Nurse	83	1024	941
Enrolled Nurse	1110	4984	3874
Registered Midwife	19	512	493
Enrolled Midwife	132	3656	3524

Source: Health Sector Development Plan 2012 – 2016 (GRSS-MOH 2012)

The current health workforce is skewed to a poorly trained low-level professional and auxiliary staff. According to the HSDP only about 10 % of the civil service posts are filled by qualified health workers. The gap is partially covered by means of an informal "task shifting" to less qualified staff, such as Community Health Workers (CHW) and Community Midwives (CMW) with a diverse training background. Some have just some weeks or months of training or no training at all and others have more formal training (9–18 months). Additionaly Traditional Birth Attendants (TBAs) are employed by health facilities such as PHCCs, PHCUs and even at County- and State Hospitals the maternity wings are mainly staffed with TBAs. The TBAs are included on the payroll system, but receive a very low monthly salary (less than 50 $) which lead to a maintenance of traditional payment forms such as *a goat* for a delivery. The distribution of the qualified HRH is also very unequal throughout the country, as most trained cadres such as nurses/midwives and physicians are based in urban areas.

According to the table above there seem to be a clear ambition to scale up the number of nurses/midwifes at both registered level and enrolled (certificate) level. According to the table the main cadres in the HSDP seem to be the enrolled nurses/midwives. This corresponds with an understanding of the enrolled level as a *practical level*, designed to train practical nurses and midwives working at operational levels in the community such as state/county hospitals, health centers, PHCCs and PHCUs. The registered level of nurses/midwives is often understood as more directed towards hospital setting, with managerial and leadership functions.

In addition to this relatively ambitious plan in the HSDP to increase training and recruitment of locally trained HRH, the idea is to supplement with regional recruitment from Northern Sudan, Ethiopia, Kenya, Uganda and Tanzania.

According to earlier drafts of the Health Sector Development Plan (March 2011) the strategy was to give the Community Health Workers (CHW) a pivotal role in the Community Health Program and a key role in minimum service provision. Additionally the community health care was to be provided by Maternal and Child Health Workers and Home Health Promoters. However, in the final version of the Health Sector Development Plan 2012 – 2016, the role of the Community Health Worker and other low-level cadres seem to have been played down and the policy seem to have changed. The role of CHW is hardly mentioned in the final document and appears rather vague in the policy.

3.1.3 Regulation of Nursing and Midwifery education - What policies are in place?

At the moment there is no specific regulatory body for nurse and midwife cadres at place in South Sudan, unlike the situation in most African countries. All existing regulations are done by the MOH directly. According to our information the process of putting into practice proper regulation systems for nurses/midwives in terms of legislation, scope of practice, accreditation and other important structures for regulation is not very advanced. The information we received from various stakeholders indicate that there are ongoing discussions and diverse positions on this matter. Key persons in nursing/ midwifery wants to establish a regulatory body, a **Nurses and Midwives Council**, to take care of issues like standardization of curriculum, development of scope of practice for various cadres, as well to take responsibility for licensure exams, the licensing of nurses and midwives to practice, and to implement a system for monitoring/supervision, assure plans for CPD and in-service training etc. At present, steps have been taken to establish such a system and put in place a legal foundation for it. However this process seems to have been hampered by a resistance from important stakeholders within the MOH- system. A concurrent position is to establish (revitalize) the South Sudan Medical Council and organize all health cadres under this body.

At present the responsibility for nurse/midwife education is under the Director of Training in the Ministry of Health. Under his Authority is the Directorate of Nursing and Midwifery Services, headed by the Chief Nurse Director.

(i) East, Central and South African attempts of policy alignment

These days many efforts are being made to try to align and assure quality and to put in place comparable professional regulation systems of nursing and midwifery in various countries of Africa (in line with global standards, but contextualized). African Health Professional Regulatory Collaborative for Nurses and Midwives (ARC) was established in 2011 to facilitate South to South collaboration around professional collaborative issues, such as scope of practice, licensing, accreditation of training and continuing education. ARC is supported by PEPFAR and CDC as well as Commonwealth Nurses Federation. Partner members of ARC are countries of East, Central and Southern Africa-Health Community (ECSA-HC). Malawi is one of the partners and has received

grants to develop a system for CPD for nurses/midwives in the country. South Sudan is at current seeking to become a partner of ARC, and have since 2012 participated in meetings and will (according to our information) receive support to develop a scope of practice for nurses/midwives. The absence of a regulatory body in South Sudan is a hindrance to the development of regulation issues in South Sudan.

(ii) Standardization measures

While the discussions concerning the professional regulatory body continue and the result of them is not clear, several measures are put in place to regulate the nurses and midwives professions. The two most important is:

- Standardization of curriculums for
  - reg. nurses (3-year diploma)
  - reg. midwives (3 year diploma)
  - enrolled/certificate nurse (2 ½ years certificate)
  - enrolled midwife (2 ½ years certificate)
- Standardizing of final exams for reg. nurses and reg. midwives
  - establishing a national examination board
  - developing and running the first national exam (2013)

The development of standardized curriculums for two levels of nurses and midwives (registered nurse/midwife and enrolled nurse/midwife) may be an important step towards a quality assurance of the graduated health care workforce.

At present there seem to be more vague plans for establishing a plan for Continuous Professional Development (CPD), systems for monitoring and evaluations (M&E), as well as other mechanisms to regulate the nursing/midwife profession.

(iii) ***Comments to the two curriculums*****:**

To get an overview over the two existing standardized curriculums in use in South Sudan, the curriculum for diploma midwifery and the curriculum for enrolled midwifery the assessment team analyzed and compared the two curriculums (see summaries of the analyses in annex 2 and 3).

One striking concern is the similarity between the two curriculums as both entrance requirements, courses and content such as learning outcomes in both theory and clinical parts of the curriculum are only differing slightly. Another concern is that the two curriculums seem not always very well adapted to the realities of South Sudan. One example is *Course 2: Foundations in midwifery practice*, where a lot of emphasis is on learning the regulations and legislations of midwifes – not mentioning that in South Sudan these structures are not in place at the moment. A variety of learning methods is included in the so called "learning resource package" displayed in the curriculum for both programmes: Illustrated lectures, case studies, role play, video, skills practice sessions and clinical simulations are all methods to be used. The question is if some of these teaching and learning methods are realistic regarding the resources available at most of the existing training institutions at the moment. Community Midwifery seems almost equally emphasised in both curriculums, not much reflecting the different roles of the two cadres. Course assessment is designed equally for both programmes using a

range of both formative and summative assessments to evaluate the students' competencies, such as assignments, quiz, logbook, student presentations, portfolio OSCE in addition to final written exams final practical exams, project work and final case study (see chapter 4 for a further discussion on this matter). The overall impression of the two curriculums is that they are quite ambitious and probably not very well adapted to the context.

3.1.4 Association for nurses/midwives

According to the information we received there is a national association of nurses and midwives in South Sudan, namely SSANAMA (South Sudan Nurses and Midwives Association) established in 2011 with support from UNFPA. The objective of the association is to strengthen and coordinate efforts to raise the practicing standards of nurses and midwives in the country. The association is also aiming to promote the status and interest for the profession and to encourage ethical and professional conduct within its member groups. According to our information the association has local branches in each of the 10 states. There is also a separate midwifery chapter under SSANAMA called "Society of Midwives in South Sudan" (SOMOSS). However, we also received information that these associations were not very active and struggled to be recognized as a stakeholder by the MOH. According to our information the necessary legal measurements seem not to be in place for SSANAMA to be formally registered as a national association.

3.2. International donors and NGO's roles related to training of nurses/midwives

A number of international donors, NGOs and FBOs are involved in South Sudan's health system. A patchwork of funding organizations is involved in the funding of various parts of the training such as tutors salaries, students scholarships, financing infrastructure etc. Another number of NGOs and FBOs are involved in operation of the various training institutions and implementation of their respective programmes. The assessment team had interviews with several of the most central organizations involved in nurse/midwife education to get a clearer picture of their role. The interviews served as key information sources to the comprehensive picture of the situation regarding nurse/midwife education in South Sudan.

3.2.1 United Nations Population Fund (UNFPA)

UNFPA plays a key role when it comes to development of human resources for health and health training institutions in South Sudan. UNFPA has been active in South Sudan for 2 years.

The Midwifery Program is the "flagship" of UNFPA. The program has 4 Components:

1) **Education -** For the time being they are supporting Midwifery Training in Juba, Wau, Maridi and Kajo Keji. UNFPA is not an implementing partner but is funding the training institutions with money from CIDA. UNFPA engage implementing partners such as IMC and other organizations.

2) **Regulation -** UNFPA provides technical assistance to the Ministry of Health and the MOH's Director of Nursing. UNFPA has also assisted the MOH in the development of strategic plans for each school. For the time being they are working on an in-service training manual elaborated by the University of Southampton in UK.
3) **Advocacy -** UNFPA has provided technical support to help MOH towards a draft bill for nurses and midwives.
4) **Association -** The foundation of the national nursing association SSANAMA has been supported by UNFPA. The association has branches in all the 10 states.

In addition to this UNFPA is seconding midwives to health facilities around the country (at the moment 18). Medical doctors are also sent for higher studies with funding from UNFPA.

3.2.2 International Medical Corps (IMC)

International Medical Corps is another central NGO in the HRH area in South Sudan. IMC is a global, humanitarian, nonprofit organization working with health system strengthening as well as relief and development programs. IMC has been in South Sudan since 1994. Currently IMC is working with the MOH to strengthen local health care capacity but also to deliver health services in more than 70 health facilities. By now the organization support two county hospitals, 11 PHCC and 63 PHCU and three midwifery schools (Juba, Wau and Kajo-Keji).

The UNFPA engaged IMC as an implementing partner for nursing/midwife education. In Wau and Kajo-Keji the training school programs implemented by IMC are for enrolled midwives (2 ½ years program). In addition it implements a 1 year bridging program for Community Midwives (CMW) to transform them to become enrolled/certified midwives. In Juba (JCONAM) the programs are 3-year programs for registered Nurses and registered Midwives. IMC works close with the GRSS-MOH/UNFPA on these programs. The MOH selects the students and is responsible for the curriculum. IMC has funds from Canadian International Development Agency (CIDA) through UNFPA that will last until 2015-2016. The vision is that the MOH will be able to take over the colleges and run them after that. IMC is responsible for recruitment of tutors at the training institutions they manage. At JCONAM all teachers (except for two tutors that are locally recruited) are recruited by IMC and will disappear if ICM terminates its involvement (for instance if the funds from CIDA stops). At JCONAM the principal is recruited by the MOH, and in Kajo-Keji a person gets training as a principal now. Only in Wau the principal is employed through IMC. According to IMC, JCONAM, Juba, is the most prepared college to take over management of the college.

3.2.3 African Medical Research Foundation (AMREF)

AMREF has been involved in South Sudan since 1974. Today AMREF has a very close relationship with the Ministry of Health and is an important player in their policy making. AMREF is involved in several research activities and is currently running an international "Stand Up for African Mothers" Campaign. One of the goals of the

campaign is to train 15 000 midwives by 2015 to reduce maternal deaths in sub-Saharan Africa and to bridge the gap in meeting the Millennium Development Goals.

In 1998 AMREF started training of clinical officers in Meridi. Today 300 clinical officers have been trained in total. In addition AMREF has trained community midwifes and enrolled nurses. The education program for community midwifes has stopped since MOH decided to phase out training of this cadre in South Sudan. This is a decision AMREF disagrees with. Today AMREF has 45 students in the clinical officer study and 30 midwifery students in Meridi. AMREF has funding officers in Europe. 50% of the funding for the training institution in Meridi comes from Italia.

To scale up the female enrollment in health training institutions, AMREF has embarked on a model called Women in School Health (WISH). The background for this approach was the observation that women intake in the health training institution was minimal compared to the men. The initiative has started a secondary school to allow women to take up science subjects and empower them to enroll in the health training institutions. This program will work in three phases (initial, stabilization and hand over), and in each stage there will be 3-years of implementation. The school has an enrollment of 50 girls who according to the plans will be absorbed in the Health Training Institutions.

3.2.4 Medical Emergency Relief International (MERLIN)

MERLIN came to South Sudan in 2004. At present their major work is primary health care centers (PHCC), but they are also running a hospital in Jonglei. Merlin has a long experience in training health personnel especially when it comes to in-service training.

MERLIN put in a bid for the Health Pool Fund and won the bid for to counties in Eastern Equatoria. The organization is now running all the health facilities from employment to equipment. The priority from the Health Pool Fund is safe motherhood. The existing grant MERLIN has is for 3 ½ years.

According to Merlin it is a problem that the Health Pool Funds are not providing funds for infrastructure. Merlin has received funds to finance training of two midwives, but as they say; if there is no maternity wing at the PHCC they will not attract any midwives. Therefore they have problems to meet expectations from the donor of having midwifes trained and employed.

Merlin provides mentorship for the counties and gives guidance to the health personnel at the PHCCs/PHCUs. Merlin has elaborated a work plan to the Health Pool Fund and is monitored/evaluated after this work plan.

3.2.5 Norwegian Peoples Aid (NPA)

NPA has a long history in South Sudan. They started training of nurses/midwifes in 1995 and from 1999 the school has been located in Yei in Eastern Equatoria. At present they have 3 different programmes at the training institution in Yei: Enrolled nurse, Enrolled midwife and Laboratory technicians. In 2009 they wanted to handover the school to the MoH, but up until today they are running it themselves. At first the school was financed by Ministry of Foreign Affairs, but now NORAD has taken over and has planned to finance the school until 2014.

MOH is responsible for the admission. Before "we used to take any kind of educational backgrounds and train them". Now the intake has to follow the standard criteria. The students are accommodated in student full board hostels at the Yei training institution.

All the tutors at Yei are from South Sudan. Some of them are paid by MOH. Some tutors were sent to be trained in Tanzania. The tutors form the school board. MOH are supposed to come regularly for M&E, but according to our information they come very rarely.

3.2.6 Canadian International Development Agency (CIDA)

CIDA is mainly into maternal and child health and food security. In 2010 they made the decision to increase their funding. Within the strategy was to improve obstetrical care and train more nurses/midwifes. According to our information, CIDA is the only funding partner for UNFPA in the area of training of nurses and midwives in South Sudan.
In addition to the support of training institutions CIDA is supporting 8 maternity health wards with new buildings, also through UNDPF.

3.2.7 World Health Organization (WHO)

WHO country Office in South Sudan has as its main objective is to train medical doctors for specialized training in obstetric and emergency care. At present 20 doctors are sent to Ethiopia for training. Currently there is an ongoing restructuring of maternity units and maternal waiting centers with funding from Canadian Agency (CIDA). WHO is responsible for 4 state hospitals in Wau, Bor, Yambio and Malakal. Maternity wings are to be renovated. Being a pilot project, the maternity wings will have 24 beds and the maternal waiting homes will have 32 beds.

3.2.8 Other partners involved in training of nurses/midwives

In addition to the mentioned donor organizations and NGOs involved in training of health personnel (nurses and midwives) also other organizations are involved. To our knowledge NORAD is involved in funding of the school in Yei, UNDP is involved in funding of infrastructure and tutors at Wau School of Midwifery and Malakal HTI. AAH-I is implementing the Maridi Nurse Training School. In addition to this several FBOs are involved in training of nurses/midwives: Caritas, CDOT and Misario are all involved in the school in Kapoeta. CCD and *Solidarity for South Sudan* are both involved in Catholic Health Training Institute in Wau. Mary Help of Christians is involved in Mary Help Training Centre in Wau. An Indian FBO is apparently involved in the training institution in Bor. Presbyterian relief and development Agency (PRDA) and Australian Church is involved in the training School in Leer.

3.3 Mapping of the existing health training institutions for nursing and midwifery in South Sudan

It is a difficult task to get an overview over existing training institutions for nurses and midwifes in South Sudan. The latest written information available seem to be "Off the road: The Mapping of Health Training Facilities in Southern Sudan" which were done in June/July 2010, on the initiative of Ministry of Health and effectuated by Marc Beesley

from Liverpool Associates in Tropical Health (LATH). The problem with this assessment is that is has acquired a reputation of not being accurate enough in many of the details, and in addition it starts getting old; Quite a few things have happened since 2010 – institutions have been closed and other institutions have reopened, some of the planned reconstruction/rehabilitation have not been effectuated but others have been done, even if they do not figure in the planning documents. The problem of getting an overview is also related to the fact that so many organizations and private implementers are involved in the task of developing the health workforce in South Sudan. In addition to this, the policy of standardization of curriculums and attempts to phase out several of the former teaching programs has made the information from the mapping outdated.

When we asked various stakeholders in the MOH, the state MOHs, and NGOs and training institutions, the answers differed. This indicates that most people lack information. However, we started from the identified nursing and midwifery facilities mentioned in the mapping from 2010 and tried to verify which of them are closed, which ones has reopened, where there has been reconstruction and building/establishing of new training facilities etc. So far we have ended up with the presented table (Table 2). The sources we used for verification was partly written reports mentioning health facilities and information from people we interviewed during the field visit.

Table 2: Overview over nursing and/or midwifery training institutes in South Sudan

State	Name of Health Training Institution	Owner	Imple-menter	Funding	Program offered	Function
Central Equatoria	JCONAM	GRSS-MOH	IMC	CIDA, UNFPA	Diploma Nursing	function
					Diploma Midwife	
	KajoKeji Nursing School	GRSS-MOH	IMC	CIDA, UNFPA	Enrolled	function
	Yei National HTI	GRSS-MOH	NPA	NORAD	Enrolled Midwife and Nurse	function
Western Equatoria	Maridi National HTI	GRSS-MOH	AMREF	CIDA, UNFPA	Reg Midwife?/Nurse	function
	Maridi Nurse Training School	AAH-I Action Africa Help International?	AAH-I		Enrolled Midwife? Enrolled nurses?	function
Eastern Equatoria	Torit	State- MOH	State-MOH	State- MOH	Former Khartoum- Now Enrolled Nurse	Not fully function
	Kapoeta	Caritas CDOT	Caritas CDOT	Misario?	Enrolled nurses and Midwifery?	Under construction
Western Bahr el Gazal	WAU School of Midwifery	GRSS-MOH	IMC	CIDA, UNFPA, UNDP	Enrolled Midwife	function
	Mary Help Training centre for nurses and health workers	FBO (catholic church)	FBO MOH		Diploma Nursing Enrolled midwife	function
	Catholic Health training Institute	FBO (catholic church)	FBO MOH	CCD, UNFPA	Diploma Nursing	function
					Diploma Midwife	
Northern Bahr el Gazal	Aweil Nursing School	State- MOH				Not fully functioning (like Torit) Plan to rehab
Upper Nile	Malakal HTI?	State-MOH originally MOH handed over to		UNDP?	Former Khartoum- Now Enrolled Nurse	Not function-ing

		state in 2011 and stopped functioning				
	Renk?	**State MOH**			**Former Khartoum- Now Enrolled Nurse**	**Not func-tioning**
	Upper Nile HTI?					
Warrap	**Tonj Nursing school?**	**State- MOH**				**Not func-tioning – plan to start**
	Lou Nursing School?	**South Korean NGO?**			**?**	**?**
Jonglei	**Bor**	**Indian FBO (Christian doctors and dentists)**			**Registered midwives? Certificate nurses?**	**Not yet In 2014?**
	Jonglei Health Training School					**?**
Lakes	**Rumbek Nursing School**	**GRSS- MOH CISP (Italian NGO)phased out MOH took over**			**Enrolled nurses? Enrolled midwives?**	**About to re-open – buildings to be restored**
Unity	**Leer Community Midwifery Training School**	**State MOH?? Presbyterian Relief and Development Agency (PRDA)**	**FBO**	**Australian Church**	**18 months course Enrolled midwives?**	**Not fully functionin g (like Torit) Plan to rehab.**
	Bentiu Nursing and Midwifery	**?**	**?**	**?**	**?**	**?**

There is little literature documenting the history of nursing and midwifery in South Sudan. Our information is that the various training institutions have delivered different educational programs and have used a variety of curricula. Several training institutions have used a curriculum from Khartoum and most of the Sudanese tutors active today have received training from Khartoum. The Khartoum curriculum is delivered in Arabic language. The Khartoum curriculum is now being phased out in South Sudan and has been replaced by the new curricula (see for example the training institution in Torit). In the years after the CPA, several training institutions started up using different curricula. One example is the Catholic Training Institution and Mary Help Nursing School in Wau where they used a 3 ½ year programme for Community Midwives based on a curriculum from Kenya. This curriculum is currently replaced by the new standard curriculum, and the students were transferred to the new programme (RN-programme).
There are at the moment at least three training institutions offering a diploma in nursing and/or midwifery (following the standardized new curriculum 2011).

a) Juba College of Nursing and Midwifery (JCONAM), Juba
b) Mary Help Nursing School, Wau
c) Catholic Health Training Institute, Wau

They are all using the same curriculum which is currently under revision. The review is coordinated/lead by a UK nurse educator, Professor Bill Reynolds, who has carried out meetings (workshops) with principals and tutors at the colleges/schools offering a Registered Nurse/Registered Midwife program.

3.4 Site visits at nursing /midwifery training institutions

The needs assessment team visited a total number of 6 training institution during the field visit in South Sudan. The institutions were located in 3 states, one in central Equatoria, 2 in Eastern Equatoria and 3 in Western Bahr El Gazal. The visited training institutions were in different shapes and conditions and 1 was not functioning (under constructions). 3 were offering education at diploma level and 4 offered certificate programmes.

3.4.1 Central Equatoria - Juba College of Nursing and Midwifery (JCONAM)

Juba College of Nursing and Midwifery (JCONAM) seem to have been granted the role as *"the flagship"* of GRSS-MOHs new efforts to revitalize and restructure nursing/ midwifery education in the new nation of South Sudan. The college was established with the support from a consortium of partners; UNFPA, Real Medicine Foundation (RMF), World Children's Fund (WCF), World Health Organization (WHO) and Japan International Cooperation (JICA), UNDP/Global Fund Health Systems, St. Mary's isle of White – Juba Link. This is the first *college* of nursing and midwifery ever in South Sudan. It opened in May 2010 with 40 students, of which 20 nurses and 20 midwives enrolled in a three year program. At the beginning the training institution was hosted in a temporary location waiting for a new campus to be constructed. The new facilities were finalized in 2011. At present the college has two departments, nursing and midwifery. The first group of students graduated (13 nurses and 17 midwives) with a stylish graduation ceremony in august 2013.

Table 3: Students at Juba Colleges of Nursing and Midwifery

Year of intake	Programme		Remarks
	Registered Nurse	Registered Midwifery	
2010	20	20	13 nurses and 17 midwives graduated in August 2013
2012	30	30	Currently in 2nd year
2013	30	30	Currently in 1st year
Total	80	80	

Clinical training:

A master rotation plan for JCONAM has been developed to guide the implementation of the curriculum with both theoretical and clinical lessons – (until 2016). The students go for clinical training at Juba Teaching Hospital and rotate within medical, surgical, pediatric and gynecology units. The main responsibility for supervising the students is with the hospital staff. According to the principal of JCONAM, Juba Teaching Hospital have 25 registered nurses/midwives employed (most of them trained in Khartoum), all engaged in supervision of students. According to the principal there are also particular clinical instructors at the hospital; these have been trained for 1 week by UNFPA. In addition the VSO-tutor at JCONAM has a particular responsibility for clinical instruction of students. The students also go for clinical training at 4 different Primary

Health Care Centers (PHCCs), all of them are in Juba, none in rural areas. According to our information most of the students at JCONAM come from rural area. They come from different states and were supposed to go back to their respective states after graduation. However, MOH have decided to keep all the new Registered Nurses/Registered Midwives graduated in August 2013 for the needs in Central Equatoria.

Infrastructure:
The students at Juba College are not paying, but since the hostel is not ready – they have private accommodation and are receiving an allowances for food of 200 US$ a month for accommodation /food.
Accommodation: The dormitory is under construction and will accommodate 200 students. Included in the dormitory section are kitchen, dining room and bathroom facilities.
Teaching facilities: 4 classrooms, library (have received donation of books), a standard skills-laboratory – fully equipped with different material and models, furnished by UNFPA. IT room with 20 (?) PC/laptops, internet access, wireless internet service (also for the Juba Teaching Hospital at their Resource Centre). The access to internet is relatively stable.
Administration facilities: One block with tutor offices, No tutors accommodation available.

Human resources
The college currently has 12 tutors of which 4 are nationals including the principal Petronella Wawa, 2 of the national tutors have a RNM, one is registered nurse and one is nurse tutor. The international staff is mostly from other east African countries (Kenya 2, Ethiopia Uganda 2) and from Zambia Burundi. The VSO is British. The volunteers have a diverse background with minimum diploma level, although most of them have BSc level and some have Master degrees. 3 are International United nations (IUNV) - volunteers from UNFPA (IUNV), 1 is VSO, and another 4 are IUNV-volunteers from UNDP.

Table 4: Teachers at Juba Colleges of Nursing and Midwifery

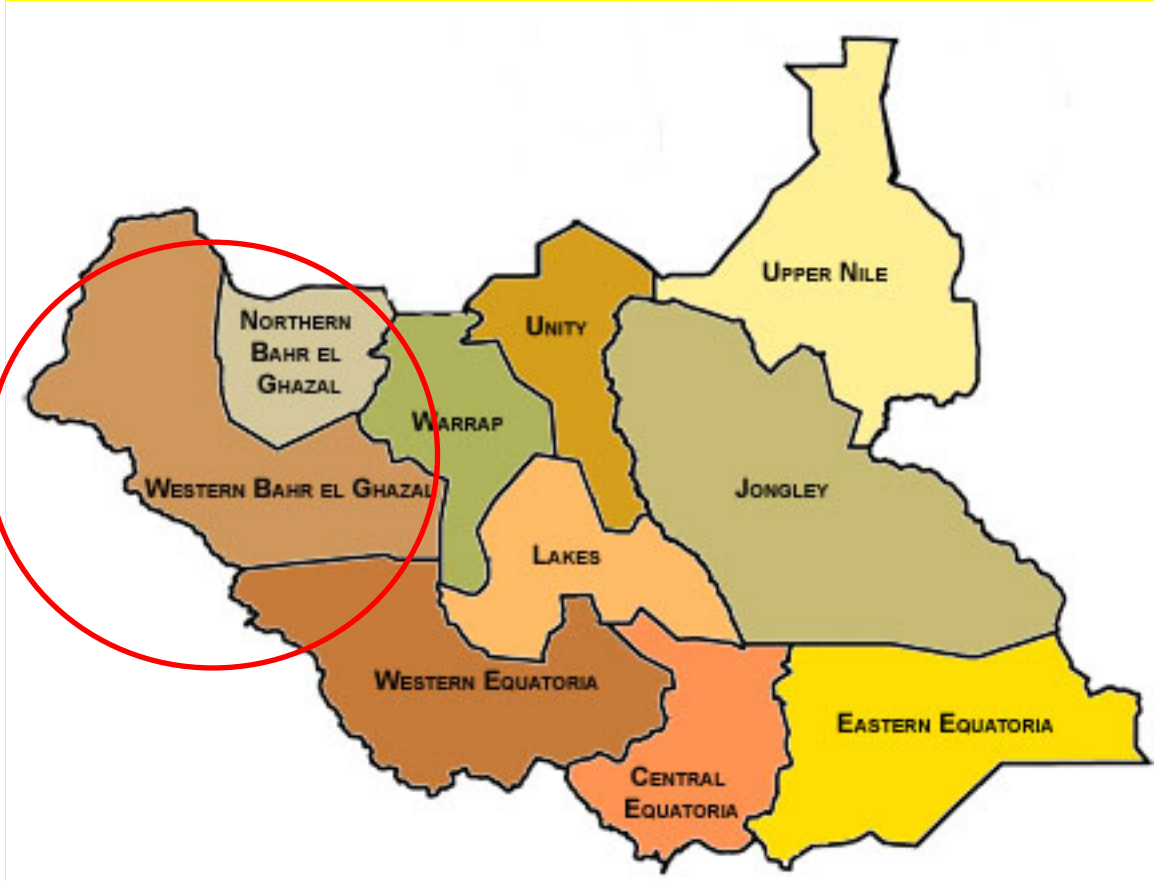
No.	Position	Level	Employer/ Organization	Nationality
1	Principal	RNM	MOH	South Sudanese
2	Nurse Tutor	RN	MOH	South Sudanese
3	Nurse Tutor	N	MOH	South Sudanese
4	Midwifery Tutor	RNM	MOH	South Sudanese
5	Nurse/midwifery tutor	MPH, BScN, RN, RM	IUNV-UNFPA	Kenyan
6	Nurse/midwifery tutor	BScN, DNE, RM, RN	IUNV-UNFPA	Zambian
7	Nurse/midwifery tutor	MPH, RM, RN	IUNV-UNFPA	Ethiopia
8	Clinical Nurse Tutor	RGN	VSO	British
9	Nurse Midwife tutor	NM	IUNV-UNDP	Ugandan
10	Nurse Midwife tutor	BScN, RNM, CICU	IUNV-UNDP	Ugandan

11	Nurse Midwife tutor	BScN, KRCHN, MSN (student)	IUNV-UNDP	Kenyan
12	Nurse Midwife tutor	RNM, MPH, PhD student	IUNV-UNDP	Burundian

Management of the college

Although JCONAM has a principal on permanent employment, she is not responsible for the budget of the college. According to our information JCONAM is managed by International Medical Corps (IMC), and IMC is responsible for the budget, recruitment of tutors, payroll systems etc. According to the principal there is no process for handover of the management put in place so far.

3.4.2 Western Bahr El Gazal



Source: afro-ip.blogspot.com South Sudan 2011/2012

The state of Western Bahr El Gazal is divided into three counties; Wau County, Jur River County and Raga County. Wau teaching Hospital in Wau, is run by GRSS –MoH, The State-MoH is responsible for most of the other health facilities. According to the State MoH, Human Resources & Training Department, the number of health facilities in the state is 1 county hospital, 1 community hospital, 1 military hospital and 1 private hospital, 22 Primary Health Care Centre's (PHCC) and 68 Primary Health Care Units (PHCU).

When it comes to available training facilities for Nurses/Midwives, Western Bahr El Gazal and the state capital city of Wau, seem to be in a unique position within the country of South Sudan. At present there are 3 functioning training institutions in Wau. In addition the city of Wau hosts the University of Bahr El Gazal (UBG) which is a public university, established in 1991. According to our information the university has a Faculty of Medicine and Health Sciences as well as an institute of Public Health. Unfortunately the assessment team did not have the opportunity to visit the University, but according to the information we received there is little formal collaboration between the university and the nurse/midwife training institutions in Wau except that according to our information a representative from the University of Bahr El Gazal is a member of the examination board at Mary Help Nursing School.

3.4.2.1. WAU School of Midwifery, Enrolled level

Wau school of Midwifery is a government/MOH operated school for training of enrolled midwives. The school used to train community midwives. It was closed during the war, but reopened in 2012. The CIDA funds the program through UNFPA. IMC is implementing partner. UNDP has a role in construction and renovation of infrastructure, provision of furniture and books for the library. UNDP is also funding 2 tutors.

Foundation courses:

The school started up in September 2012 with a foundation course. Since many of the potential students have an Arabic secondary educational background upgrading of knowledge in English is necessary. As many of the students do not have a science background from secondary school, they also get biology, physics and mathematics.
The program is based on the standard curriculum for enrolled midwives, a 2 ½ year programme leading to a certificate in midwifery. Those who passed the foundation course started up on the ordinary program in January 2013. Those who failed the foundation course plus new applicants in currently getting lessons in English. Also an English course for community-health workers (CHW) takes place at WAU School of Midwifery, during the afternoons in the schools facilities.

Table 5: Students at WAU School of Midwifery

Year of intake	Programme – Enrolled Midwifery	Remarks
2012		30 students started up in September with a 3 months foundation course
2013	21 (22)	A new group of students attend the foundation course to qualify for enrollment in 2014

Currently 21 students are in the programme. One boy did not come back after the vacation. At present there are 12 male students and 9 females. Currently they are in the second semester. The first semester was mainly theory. All students come from Western Bahr El Gazal.

Infrastructure:
Accommodation: The students commuted from their homes in the beginning, but since May 2013 they are accommodated in the new hostels, one for boys and one for girls.
Teaching facilities: Two classrooms, Skills lab with some (quite sparse) equipment and models, no beds, IT-lab with about 10 PC/lap tops, Library with some books,
Administration facilities: Two administration rooms, No teacher houses.
1 vehicle (challenge is transport of students to the health centers and hospital–since they have only one vehicle)
Human resources:
The school has 3 tutors

- Principal-manager coming from Uganda with a 1 year contract. She stays in a guesthouse (no teacher house so far at the campus)
- Two midwifery Tutors (UNDP Volunteers from Uganda and Kenya)
- In addition they get some teaching help I pharmacology and English from volunteers from the KenBatt UN Force.

Table 6: Teachers at WAU School of Midwifery

No.	Position	Employer/Organization	Nationality
1	Principal (one full time)	GRSS-MOH	Ugandan
2	Midwifery Tutor (full time)	IUNV-UNDP	Ugandan
3	Midwifery Tutor (full time)	IUNV-UNDP	Kenyan
4	Pharmacology (part time)	Volunteer KenBatt	Kenyan
5	English (part time)	Volunteer KenBatt	Kenyan

Clinical training:
The clinical training is at Wau Teaching Hospital and at another smaller hospital in Wau, and 4 health centers (PHCC) in Wau (not rural areas). The teachers assess the students themselves and are, according to the information we received, present together with the students in the clinic. The students use a logbook which is elaborated at national level to attest their abilities in clinical procedures. When we enter the classroom the students are present in the middle of a teaching session. They are all in uniforms, they rise up and greet the visitors and when asked why they joined the nursing profession, they all answer the same; "*We want to go back to the community and serve the people".*

Management of the college
In the same way as JCONAM the principal at Wau School of Midwifery do not have responsibility for the budget of the school. According to the information we received the school is managed by IMC (International Medical Corps), and IMC is responsible for the budget, recruitment of tutors, payroll systems etc. There is at present no particular plan for the recruitment of new teachers. According to our information there are no plans for handover of the management functions.

3.4.2.2. Mary Help Nursing School, Wau

Mary Help association started up in the ***Diocese of Wau*** in 1989. Principal, Sister Gracie Adichiragil (from India), started courses for nurses in 1999. But as late as in 2007

the Nursing School opened and started up offering a 3 ½ year programme for Registered Community Midwives using a curriculum from Kenya. 23 students graduated under that programme. In 2010 the curriculum changed to the 3 year Programme for Registered Nurses (in line with the MOH-policy). In addition Mary Help Nursing School at present offers a 2 ½ year programme in Enrolled Midwifery (using the standard curriculum).
Earlier Mary Help used to train community health workers, but this programme was phased out.

Table 7: Students at Mary Help Nursing School, Wau

Year of intake	Programme		Remarks
	Registered Nurse	Enrolled Midwifery	
2010	17 (11)	12	11 graduated as RN in August 2013 12 graduated as certificate midwives in 2013
2011	20	0	Currently in 3rd year
2012	17	24	Currently in 2nd year
Total	54	36	

Clinical training:
Getting quality clinical training is a big obstacle for Mary Help Nursing School. Currently the situation at Wau Teaching Hospital is very difficult as a consequence of a tragic event at the hospital some months ago where a delivery went wrong (death) and the husband came to the hospital and accused the staff of killing his wife and shot and killed one of the doctors. As a result of this very few people are coming to Wau teaching hospital for deliveries for the time being. The students therefor have to go to Comboni Hospital to do clinical practical to be able to achieve the required deliveries. The required number of deliveries (50 for RM and 40 for enrolled (assisted/observation) is difficult to obtain. The quality of the clinical training is also a challenge. At present no preceptors or clinical instructors are trained from the nursing school. It is very difficult to identify good nurses/midwifes to train as the maternity wings are staffed mostly with lower cadre nurses/midwives. A collaboration concerning student's assessment and guiding is not established.

Infrastructure:
Accommodation: The students commuted from their homes – there is no student hostel available – the college offer tuition-only
Teaching facilities: Two classrooms (?), Skills lab with some (quite sparse) equipment and models, IT-lab with about 10 PC/lap tops, Library with some books,
Administration facilities: Two administration rooms, Accommodation for tutors available.
Sister Gracie has great plans for the future including a plan for a construction of a new hospital and a new school campus. The plot is already identified, plans are available and preparation for constructions has just started.

Table 8: Teachers at Mary Help Nursing School, Wau

No.	Position	Nationality
1	Director (one full time)	Indian
2	Principal (one full time)	Indian
3	Teachers (2 full time)	Indian
4	Teachers (4 part time)	Kenyan
5	Teacher (1 full time)	Scottish
6	Visiting Tutors (3)	Egyptians
7	Visiting Tutors (1))	South Sudanese
8	Visiting Tutors (1)	Slovakia
9	Visiting Tutors (1)	USA
10	Visiting Tutors (1)	UK
11	Visiting Tutors (1)	Canada
12	Visiting Tutors (1)	Germany

Management of the college:
Mary Help Nursing School is governed by a managing board in which Sister Gracie as the Director of the School participates. The director is responsible to the board for the budget of the school.

3.4.2.3. Catholic Health Training Institute (CHTI), Wau

The training institute started up in as early as in 1975 – initiated by Sudan's Catholic Bishop. From 1986- 2005 the place was closed due to the civil war and because of lack of security. In 2005 after the CPA, a group within the Catholic Church named "Solidarity with South Sudan" started up again. A mixed group of sisters, brothers and priests is now running the place and live in a sort of community. From 2008 they decided to start up with capacity building 3 areas; Teachers education, Nurse/Midwife Education and Pastor/Church Reconciliation and Peace Work training. In 2008/2009 the infrastructure of the training institution was rehabilitated for over 1 mill US $.
In 2010 the first group of nurse/midwife students started up. The first group consisted of 18 students, 2 from each diocese. In the beginning CHTI used a curriculum from Kenya for Community Nurse/Midwives (the same as were in use at Mary Help Nursing School), namely a 3 ½ years program to become Registered Nurses and Midwives. This was the first registered nurse/midwife programme in South Sudan ever. A 5 month foundation course in English, Biology, Christian Ethics and IT was a part of the Curriculum. Then the MOH decided to train registered nurses and midwives in two separate programs by a standardized curriculum and CHTI transferred the students to the curriculum for Registered Nurses.
The first group has graduated in August 2013: 16 (5 girls and 11 boys) passed and got a diploma in nursing (common exam with Juba and Mary Help) Two early drop outs from the total. The students from CHTI achieved very good results, as 9 out of 16 got distinctions.

Table 9: Students at Catholic Health Training Institute, Wau:

Year of intake	Programme		Remarks
	Registered Nurse	Registered Midwifery	
2010	18	0	16 graduated in July 2013
2011	11	0	Became new 3rd year
2012	24	19	Became new 2nd year
2013	19	0	2nd semester of 1st year
Total	72	19	

30 of the students at present are women which is considered a great achievement considering the fact that few women have attended secondary school in South-Sudan.

Clinical training

As for Mary Help Nursing School, to assure adequate quality clinical training for the students is the big obstacle. The current situation at Wau Teaching Hospital forces the CHTI to bring their students to Comboni Hospital to do clinical practical to be able to achieve the required deliveries. At present no preceptors or clinical instructors are trained from the nursing school. A collaboration concerning student's assessment and guiding is not established.

Infrastructure:

In general the campus of CHTI is impressive. The campus is large, the buildings are made of stones and are well maintained and in a very good shape. Most of them are built as early as 1975-1983, funded by Misereor and originally used for training of medical officers. According to the director, the plumbing system is the only problem.

Accommodation: Hostel with rooms for 100-120 students (possible with 4-6 in the room).

Teaching facilities: 6 classrooms, IT room, Library, Skillslab with 4 beds and lots of equipment for midwifery

Administration facilities: Large administration blocks with many offices for tutors

Table 10: Teachers at Catholic Health Training Institute, Wau

No.	Position	Type of Specialization	Nationality
1	Director (one full time)	Reg Nurse/Reg MW	New Zealand
2	Principal (one full time)	Reg Nurse/Reg MW	South Sudanese
3	Lead Tutor (one full time)	Reg Nurse/Reg MW	Indian
4	Tutors (3 full time)	Reg Nurse/Reg MW	Kenyan
5	Clinical (one full time)	Reg Nurse/Reg MW	Kenyan
6	Lecturer (one full time)	Physician	Italian
7	Tutor (one full time)	Reg Nurse/Reg MW	American
8	Visiting Tutors (3 From Kenyan Medical Personnel-Kenyan Battalion-UNMISS)	Doctors	Kenyan
9	Visiting Tutors (3 Consultants from Wau	Doctors	South Sudanese

	Teaching Hospital)		
10	Visiting Tutors (4 from State Ministry of Health- Primary Health Care)	Doctors	South Sudanese

Management of the college:

CHTI is governed by a managing board of 10 persons in which Sister Dorothy is a member. The board is chaired by Bishop Rudolph (South Sudanese). The CHTI is responsible to the board for the budget of the school. The funding donors are several, mainly catholic organizations from all over the world (Spain, Italy, USA and Netherlands etc). Students are not paying. Some students are sponsored by Americans who pay school fee for them. The midwifery students are funded UNFPA through MOH who recruit the students. The majority of the student comes from the Central Equatoria State (Midwifery). The question of recruitment of South Sudanese teachers has been subject to discussions within CHTI. The plan is that some of the best students graduated will be recruited to go for BNSc with the obligation to come back to CHTI to serve as teachers. There is a great need for South Sudanese nurse/midwifery teachers according to the director of CHTI.

3.4.3 Eastern Equatoria

Source: afro-ip.blogspot.com South Sudan 2011/2012

The Eastern Equatorial State has 8 counties: Ikwoto, Kapoeta South, Kapoeta North, Kapoeta East, Budi, Torit, Lafon/Lopa and Magwi. It has a population of almost 1 million according to the statistics from the Referendum in 2011. It is a great disparity in the distribution of health services in the state and according to the policy statement 2013-2014 to the Ministry of Health in Eastern Equatoria only 25% of its population are accessing health care. The state coordinates its health interventions in a three prong approach: health cluster, NGO-Forum, Eastern Equatorial Coordination meeting, through the support of donor communities and implementing partners. In the development plan for the Eastern Equatoria State for 2012-2013 they propose to construct, furnish and equip Nursing Schools in Torit and Kapoeta. The same plan is made for a Midwifery School in Nimule. For the time being there are now funds available to start this work.

3.4.3.1. Torit State Hospital, Torit Nursing School

The hospital serves the people of Eastern Equatoria as well as other neighboring states. It has a nursing school that has been teaching nursing students since 1974. The hospital has a 100 bed capacity with Medical-Surgical, Nursing Casualty, Maternity, Pediatric and a HIV-AIDS Centre. The hospital receives 1200 patients monthly. The Maternity Unit has a bed capacity of 35 patients with one labor ward. The labor ward lacks delivery beds. The water and electricity supply is in a bad condition and the sewerage system has been out of order for a long time. This had caused serious fear for outbreak of bacterial diseases. At the time of the visit we found that traditional birth attendants (TBAs) were delivering women alongside 2 trained midwives, one of them from the IUNV and the other a newly qualified community midwife.

Program at Torit Nursing School

Until 2011, the nursing school had employed a curriculum from Khartoum. The tutors have had their tutor training in Khartoum in the 1980ies. During a supervision visit from MOH, Department of nursing, the Principal was handed a new curriculum and has started implementing Curriculum for Training Certified Community Nurses. However the teachers at the school had received no training in the new curriculum. Due to shortage of tutors the students are sent to the clinical areas right from the start of their studies. They receive a salary for the work they do at the hospital. In Torit Nursing School the students use more time due to the shortage of staff to cover the subjects and lack of learning structure.

According to the Principal, the rotation of students in clinical area has no follow up or assessment, but in the end they would be expected to sit for block examinations. The students also have no log books even though the school has one book for the nursing procedure manual. Due to this dire need for tutors and clinical instructors, major assessments (ward management, nurse care of a patient and community diagnosis) cannot be undertaken.

Human Resource

The nursing school has 4 tutors and 3 visiting volunteer tutors. There is a Principal of the Nursing School who was trained in Torit and Khartoum in the 70s. He have had only

one refresher course during all this time. He qualified as nurse tutor and has been teaching since 1985.

Table 11: Teachers at Torit Nursing School

No	Position	Type of Specialization	Nationality
1	Principal	Certificated Nurse/Tutor	South Sudanese
2	Tutor	Certificated Nurse/Tutor	South Sudanese
3	Tutor	Community Health	South Sudanese
4	Tutor	Nurse Tutor/Completed Bachelor's Degree 2013	South Sudanese
5	Visiting Tutor	Reg.Midwife (UNFPA)	Ugandan
6	Visiting Tutor	(UNMISS)	
7	Visiting Doctor	Medicine(State Hospital)	

Students

Selection of students is done through advertisement from the State Ministry of Health. The students selected come from a varied background. The assessment team found that several of the students where former policemen, soldiers and from the wildlife department. It is not clear if all of them where meeting the requirement to have minimum secondary education before entering the education. It was reported to us that this cadre at times intimidates the tutors into accelerating their pass mark.

Theoretical learning sessions is normally 1-2 hour per day and then students go for clinical placements, normally without a clinical instructor. It is only in maternity unit where they will receive teaching from the UNFPA assigned midwife at Torit Hospital.

At the end of two years students graduate as enrolled nurses, and remain in the hospital or are deployed elsewhere. Their pocket money comes from the salary they receive. The salary is often delayed.

Table 12: Students at Torit Nursing School

Year of Admission	Total no.Students	Male	Female
2011	71		
2013	22	18	4

Unfortunately the number of students continues to decrease due to lack of accommodation, meals, delay in salaries and exam failure. The students who are being graduated from the school are still not up to the standard of quality service delivery.

Infrastructure:

This nursing school has only one classroom, constructed in 1974. The classroom has a capacity of 20-25 students. At the time of the field visit, the hospital had renovated an old store which is more spacious. The teaching will from now take place in this new room. Since there is only one classroom they can only educate one cohort of students. They have to complete their studies before they can start with a new cohort.

During the learning periods, the students are required to look for their own accommodation as there is no boarding facility for the students. This also applies to the tutors who have to commute daily from their homes.

The nursing school has no library, and the only books available are reference material for tutors. These books were donated by well-wishers. All the books are in custody of the Principal and are kept in a box in the staff room. On the other hand there is a Health and Public Resource Centre that was built under the support of CHASS. UNDP have provided a satellite dish and computers. The reading materials are health related and there is an assigned officer responsible for the library. However this Centre is still not well known to the nursing students. If the students and their teacher had been using this Centre it could also have improved the quality of teaching. The hospital administration had also provided a renovated room to serve as staff room for the tutors, since they for a long time had been without a place to prepare for student learning. The nursing school has no skills lab.

Challenges:
The school has no other funding partner apart from the Government. It is operating from day to day basis which are not satisfactory either for students or tutors. The tutors are over worked and demoralized with the daily running of the school, where funds are scarce. The lack of proper learning environment and supervision for both tutors and students needs to be altered urgently to meet the need for the people in the state. The school will need a policy to attract and retain tutors. Upgrading of skills for the tutors will be essential as well as recruiting new staff.

3.4.3.2. Kapoeta Nursing School
The Caritas-Catholic Diocese of Torit (CDOT) has a long history of healthcare service delivery in South Sudan. The diocese is in the forefront of establishing primary health care units within Eastern Equatoria that have served many people during the war.

Caritas built a mission hospital in Kapoeta in 2002 where the main population consists of pastoralists. The Caritas-CDOT was approved by the State Ministry of Health to proceed with plans of building a nursing school.

Infrastructure:
This followed with a grant award by the MISERER/KZE (Katholische Zentrastelle fur Entwicklungshilfe for the construction of 3 classrooms, administration block and hostels. In 2012 they got 350,000 Euro to construct this school. The building has started but has been heavily delayed due to problems with the export of materials from Uganda. The architectural drawings which were present had missing structures for a skills lab and tutors residential area. The college will be training for registered nurses and midwives, laboratory technicians and pharmacy technicians.

Students:
The selection of students will be national and they intend to utilize the criteria of the Ministry of Health and the Catholic Diocese of Wau. However looking at the location of the nursing school, which is in a pastoralists dominated area, with high illiteracy level, it is unclear to what extend the school will be able to attract eligible students from the area.

Human Resource:
The recruitment of tutors will also be done regionally (East Africa) since the capacity of South Sudanese is minimal. The plan is to have 4 lecturers in nursing, 2 lecturers in midwifery and 2 lecturers in basic sciences.

Clinical Training

The students clinical rotation will be at the Kapoeta Mission hospital which has 100 bed capacity with all the departments meant for student placement.

Constraints
Two consultants have visited the construction and given their independent evaluations. A contractor from Uganda will proceed with construction; however they will still need an independent engineer for supervision and monitoring. The project started without a satisfactory risk assessment. The funding did not include the following: staff houses, equipment and furniture for the school, solar cell system and library.

3.5 Overarching aid strategy for South Sudan

The 2011 "Aid Strategy for the Government of the Republic of South Sudan"[1] (Aid Strategy) establishes partnership principles, mechanisms for aid coordination and benchmarks for aid delivery. The strategy sets out preferences for how different aid instruments should be used and how these should guide donors and development partners in designing proposed assistance and interventions.

The Aid Strategy is aligned with the principles of the New Deal for Engagement in Fragile States which is a framework for support to fragile states endorsed at the High Level Forum on Aid Effectiveness in November 2011. South Sudan is one of the countries piloting the implementation of the New Deal. A "New Deal Compact" is to be signed in late 2013 between South Sudan and its development partners. This implies that that aid needs to be delivered with a specific focus on peace-building, state-building and government leadership. Of specific significance to this study is the emphasis of the agreement on increased use of government systems and strengthening sub-national capacities.

3.5.1 Coordination of health care service delivery financing

Reference is made to Chapter 3.2 for specific analysis of donor financing and coordination on midwife training.

Health care service delivery is funded by both Government of the Republic of South Sudan (GRSS) and development partners.

The percentage of GRSS budget all allocated to health has remained stable at about 4%, which is very low for the region.[2] The 2013 national austerity budget allocates 2.9% for

[1] Aid Strategy for the Government of the Republic of South Sudan. Ministry of Finance and Economic Planning, November 2011
[2] Sara Fox and Alex Manu, *Health Care Financing in South Sudan*, Oxford Policy Management Institute, January 2012

the health sector. The government of South Sudan has committed to decentralization of service delivery to state, county and payam levels. A portion of the budget for health is therefore transferred directly from the Ministry of Finance and Economic Development (MOFED) to the State Ministries of Finance (SMOF), from where an allocation is then made to the State Ministry of Health (SMOH). Two types of transfers are channeled in this way: conditional grants which are earmarked for salaries, operating and capital expenditures and block grants which can be used by the state according to their priorities.

The major funding source for health care systems financing remains with external donors. The current approach by donors for financing of *health service delivery* consolidates into 3 broad implementation modalities with each of South Sudan's 10 states assigned to a lead donor.

USAID through its *Sudan Health Transformation Project (SHTP II)* is responsible for two states; Central and West Equatoria,

DFID (The UK Department for International Development) through its lead in the *Health Pooled Funds* (HPF-replacing the Basic Services Fund) is responsible for 6 states; Eastern Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Unity and Lakes states. The HPF is cofinanced by DFID, the Australian Agency for International Development (AusAID), the European Union (EU), the Canadian International Development Agency (CIDA), and the Swedish International Development and Cooperation Agency (SIDA). The HPF is supporting the delivery of essential primary health care and referral health services up to county hospital level, as well as health system strengthening at the national, state, county and facility/community levels

The World Bank through its lead in the *South Sudan Health Rapid Results* project is responsible for Jonglei and Upper Nile states.

The key coordination mechanisms at national and state level for health systems service delivery management are found within the frameworks of

Budget Sector Working Group (BSWG); established to function as the main body for the Government wide coordination and planning. The groups consist of both Government spending agencies and key donors. The BSWGs are responsible for producing annual Budget Sector Plans which set Government priorities and expenditure allocations and map donor support.

State Coordination Meetings: The convener of this meeting is the Deputy Governor or Governor. During this meeting all sectors in the state are represented together with the implementing partners. The high level meeting provides for crucial decision making in matters that are high on priority to protect citizens. Work Plans and Budget are discussed for the purposes of accountability and information sharing on equitable distribution of resources.

The Health Clusters at national and state level. The major objectives of the clusters are primarily to coordinate and share information and collaboratively ensure a strong

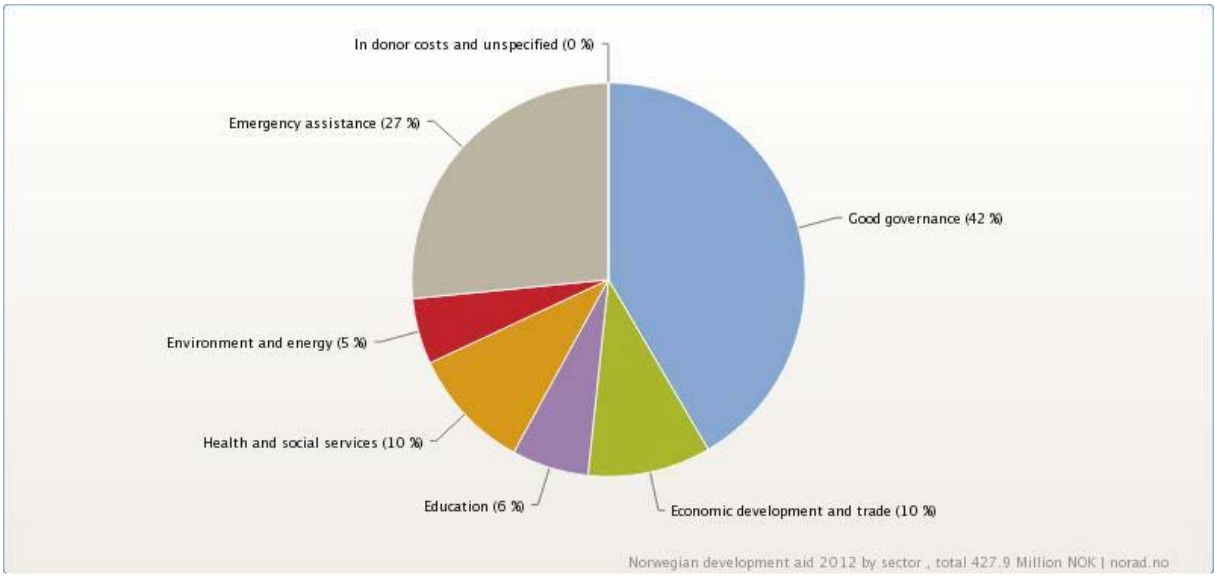
and coherent approach to health service delivery especially in humanitarian emergencies. An example of cluster leadership at state level is the international NGO Merlin which is currently the cluster lead in Eastern Equatoria having been awarded within the Health Pool Fund to lead provision of service delivery in the state.

NGO –Forums: This is not a registered body but provides a platform for a consortium of implementing partners to share experiences and constraints in their operational area.

3.6 Current Norwegian policy towards South Sudan

Norwegian assistance to South Sudan totalled NOK 247, 9 million in 2012 being an increase from 2011 which totalled 337, 8 million NOK.

3.6.1 Thematic profile of assistance in 2012



Capacity development of key governance structures remains a key objective. Norwegian support is anchored within the international principles of aid effectiveness to fragile states. As a component of this Norway heads the donors group involvement in the national budget group for social and humanitarian assistance.

The difficult economic situation has necessitated a focus to ensure that key functions are maintained. The main bi-and multilateral cooperation sectors can be summarized as follows;

(i) Oil
Agreement on long-term cooperation on the management of petroleum resources under the Norwegian aid program Oil for Development (OfD) was signed in October 2012. Norway also supports efforts to ensure sound, democratic and transparent management of oil revenues and contributed actively in the preparation of new legislation for the management of oil revenues.

(ii) Energy
Support for development of hydroelectric power from Fula Rapids on the border with Uganda. Planning is underway for the construction of a power plant with the objective of ensuring sustainable supply of hydro-power electricity primarily for Juba.

(iii) Forestry
Support for the management of the country's forest resources. 70 per cent of South Sudan's territory consists of wooded areas and a variety of teak plantations. Forestry operations are not regulated, and large values disappear unregulated out of the country every year.

(iv) Statistics
Statistics Norway (SSB) has helped to build skills to acquire, analyze and use statistics so that the government can budget and make political choices based on evidence based needs.

(v) Financial management
Norway provides technical expertise in South Sudan's finance ministry has also funded two specialist advisers to the central bank. Support for the central bank is now integrated into a new multi-donor trust fund that the International Monetary Fund (IMF) was established in 2012.

(vi) Capacity development of Public sector
Norway supports United Nations Development Programme (UNDP) and the Rapid Capacity Placement Initiative with a mentoring program where UN volunteers working alongside local staff to strengthen skills in planning, budgeting, financial management, reform of the public sector, information and communication technology, rule of law, law enforcement and national security.

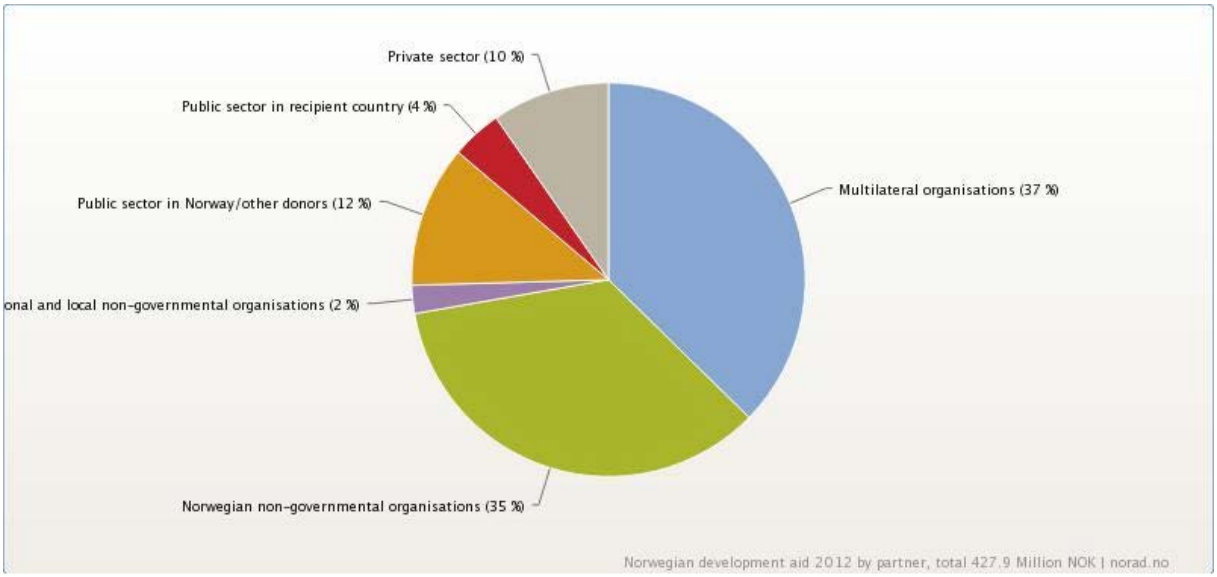
Support to enhanced human resource capacity within the health sector is an integral component of this program. Doctors, nurses and midwives from neighbouring countries have been recruited thus contributing to maintaining the services that the government itself was not able to deliver.

(vii) Sudan Recovery Fund
Together with the United Kingdom, the Netherlands, Sweden, Denmark and Norway supports South Sudan Recovery Fund, managed by UNDP. The objective is to assist the government with reconstruction through support to including agricultural projects, road construction, communication and good governance in selected states. Norway supports the construction of offices for district authorities and police in particularly conflict -prone areas. The plan is to co-locate local authorities with UN agencies and non- governmental organizations.

(viii) Higher Education
Under the NORHED program 3 projects of cooperation between UMB at Ås and University of Juba are supported. In addition Norway contributes to the construction of facilities for the Faculty of Law at the University of Juba Cooperation Norwegian support has also gone to the revision of the legal curriculum and the purchase of legal textbooks. The planning of the new National Archives is well underway. This is

Norway's gift to South Sudan and was given in connection with independence. The gift involves the construction and establishment of a national archive.

3.6.2 Channels of Norwegian assistance in 2012



Within the total support of NOK 144,863 million support to Norwegian NGOs, NPA were the largest recipients of funds with approximately 34% (NOK 50,4 million in 2012) with NCA at 15% (NOK 22 million), NRC at 10% (NOK 12,6 million), ICRC at 10% (NOK 14,7 million),MSF at 9% (NOK 12,5 million) others at 12% (NOK 17.7 million). Interestingly South Sudan Women's Empowerment Network figures under support to Norwegian NGOs with a 10% share at NOK 14,7 million.

3.6.3 Current Norwegian support to the health sector

In 2012 a total of NOK 43 million (approx. 10% of total support given) was dedicated to health as per the NORAD statistics. The main recipients of this funding were USAID - Emergency Medicines Fund which received NOK 35 million for delivery of primary health care services across South Sudan through the provision of essential medicines. The key objective of this support was to support the procurement and distribution of essential medicines and other critical health commodities in support of primary health care services in South Sudan for one year, in response to the Government of the Republic of South Sudan's (GRSS) fiscal crisis.

NPA received a grant of NOK 6 million as a bridging fund for continuing basic health services in Easter- and Central Equatoria State Sept.-Dec. 2012, until new funding from the health pooled funds of USAID/DfID came into place in in 2013.

It is worth mentioning that the NCA health program of NOK in 2012 is not classified under the statistics of support to the health sector in the NORAD statistics, only as support to NGOs.

There has been no profile so far of Norwegian support to training components within the health sector.

4. DISCUSSION

In this section we will discuss the main questions of the assessment based on the findings. Hence the section addresses 3 main questions:

- **The relation between policy and government structures and institutional capacity of health training institutions**. (4.1)
- **The current situation and problems in the existing pre-service training institutions in South Sudan** (4.3)
- **The role of relevant stakeholders regarding education of nurses/midwives** (4.4).

In addition we addressed some more **general problems in South Sudan that are influencing educational capacity (4.2)** depicted by various informants. Finally we will discuss t**he possibilities for using methodology from the Malawi-project in South Sudan (4.5)** and **the possibilities for funding of a NCA project on nursing/midwife education in South Sudan (4.6).**

4.1 Policies and government structures that may affect institutional capacity

This study is primarily informed by The Health Sector Development Plan as developed by the Ministry of Health. In the interviews the assessment group had with various stakeholders concerning the role of GRSS-MOH and its responsibility for Human Resources for Health (HRH), the picture of the policymaking and implementation of the GRSS-MOH gets quite complex and unclear. Our impression is that there is that there seem to be quite a lot of disagreement and concurrent policies in play in addition to the policy and plan displayed in the Health Sector Development Plan 2012 – 2016. This creates a quite blurred and puzzling picture the policy of HRH and especially the policy of education of nurses and midwives.

(i) Related to the political weakness in South Sudan in the area of HRH is **the absence of a regulatory body** for nurses and midwives in South Sudan. An important reason for assuring regulation and legislation is to protect the public from those who attempt to provide midwifery services inappropriately (ICM 2011). Normally a regulatory body would work close with academic staff at health training institutions as well as with profession organizations/associations to elaborate standards and quality measures for health personnel training both prior to service and in-service. In the absence of such structures, the regulation appears to be difficult and the dialogue between key stakeholders involved seems to be more random and unsystematic. According to the recommendations from WHO, active participation from nurses and midwives as important stakeholder at the health policy table should be encouraged (WHO 2010).

(ii) The current establishments of **professional associations for nurses and midwives** as well as of a particular midwife chapter are both important steps in the right direction and have been encouraged and supported by UNFPA. The challenge is now to further implement these structures and sensitize nurses and midwives to actively take part in the development and maturation of them. The goal must be to create a

strong sense of ownership and engagement in the associations from nurses/midwives working at the health service delivery level, so that the associations can be means to address issues of working conditions, professional issues as well as human rights issues both at a national level and locally.

(iii) One of the most problematic aspects with the current policy is linked to the **skill mix plans and the educational level of nurses/midwives**. According to the HSDP there are supposed to be two cadres of nurses/midwives, namely enrolled level with a 2 ½ year training and registered level with 3-years training. Looking at the curriculums for the two different programs there is little differences between the two levels. The intake criteria's are also very similar for both levels. According to the interviews with people at MOH there seem to be a view that South Sudan should phase out the enrolled level of nurses and midwifes and go for the registered level only. One argument for this view is the similarity between the two levels both when it comes to the curricula and intake criteria. Another argument is that South Sudan should have the best nurses/midwives and follow international standards. Our impression is that this may be a pragmatic position in order to try to raise the status of nurses and midwives in the country. However this may not be the best way forward to assure nurses and midwives as frontline service providers who can bring people centered care to the community where they are needed most. Striving towards international standards can only be a wise strategy if local and country-specific needs are taken into account and standards are used flexibly and adapted to realities on the ground. According to WHOs strategic directions for nursing and midwifery services 2011-2015, it is important to build institutional capacity and training/education to assure suitably skilled practitioners to provide comprehensive people–centered services (WHO 2010 p 5). According to WHO the pre-service training must be prioritized at several levels to be able to meet the country's need.

(iv) There are challenges within the Government allocation modality of direct funding from national level finance (MOFED) to state level finance (SMOF) and further to state level health (SMOH) sector in that the central Ministry of Health's *ability to coordinate national health policy will be undermined.* This is because the SMOH's will want to focus on their local priorities and will not be held accountable for achieving priorities identified by the central Ministry of Health. As a consequence, there may be duplication of initiatives and inefficient use of resources.

4.2 General issues/problems in South- Sudan influencing the area of nursing and midwife education

(i) T**he poor status and image of nurses and midwives** within the population of the country represent a particular problem. The problem of status may be linked to the particular history of South Sudan. According to our informants one of the explanations was that nurses and midwives working in the countries health facilities during the period of civil war (last 50 years?) had undergone very little formal training. Many of

them did not even have primary school prior to their training. One example is the frequent practice of employing TBAs in the midwife positions in the health facilities. It is likely to believe that this practice may have affected the status of midwifery significantly. Midwifery as something anybody could do *"My grandmother was a midwife but she had no education"*. As mention above this may have resulted in a policy with the main concern to raise the status of nurses and midwives and hence put much effort on training of higher level cadres of nurse and midwives. An evident weakness of this strategy is the lack of policy measures put in place for lower cadres. The idea seem to be to phase out lower cadres, but regarding the enormous need of health workers in the communities and the low number of graduated nurses/midwives at present, this must be a very long term strategy. In the first decades to come the rural communities of South Sudan will most probably continue to rely much on lower cadres such as CHWs and CMW and even TBAs. With the policies of education focusing diploma levels, the problem with uneven distribution of health care personnel and the low quality of HRH in rural areas risk to be aggravated.

(ii) **Gender** is another very important area related to education of nurses and midwives in South Sudan. One interesting and problematic finding is that many boys/men seem to be recruited into nursing and midwifery education lately. The reason for this may be several. A possible explanation is that more male than female students finish secondary school in South Sudan and hence become eligible for the training institutions. The recruitment of many male students can be looked upon as a resource, but there are also possible problems related to the entrance of male into the nurse/midwifery-professions. The decades of conflict and civil war in South Sudan has deeply influenced relations between men and women in South Sudan. Research describe how the militarization of the culture during the civil war has produces an ethos of manliness and unity among men and has dominated other values and civic organizations. A mythology of brotherhood created myths of women as not being as important and simultaneously producing the myth and fear that reproduction was the inevitable expression of brotherhoods in action. As a consequence feminine values suffer, gender exclusion is intensified and women's political status is greatly damaged. The occurrence of gender based violence is very high and widely accepted by both genders (Scott 2013, Jok 1999). Interviews conducted by the assessment team confirmed that gender issues was experienced as a problematic area within nursing/midwifery education – one example was the lack of respect for female tutors and female students shown by male students, many of them former soldiers, within the classroom setting. This may also be the case in clinical settings. Another problem will be when the male midwifes are put into service in rural areas where women traditionally will avoid to seek help from a male due to cultural beliefs and practices like not showing your naked body in front of other male than your husband. Women instead prefer the traditional birth attendant because they are women. A lot of sensitivity training has to take place before these beliefs will be overcome in traditional societies like South Sudan, and the male midwifes have to be trained especially on these issues.

(iii) M**otivation and retention of trained health personnel** was highlighted as a main issue of concern both at the GRSS-MOH level, at the training institutions and by other stakeholders. Although the students we met at Wau Training Institute (se section

3) and also many of the newly graduated from JCONAM expressed their commitment to go back to the community and serve the people of South Sudan, many of the educators we interviewed doubted that this would be the realities. Their experience was that many of their students tended to use nursing education as a **stepping stone** for further studies (medical studies, other university degrees) and that they were not really interested in nursing /midwifery as such. For those who decide to stay in the profession many other questions play into their future choice of workplace: Where will they be employed? Will they be paid properly? Will they have better opportunities and work conditions in neighboring countries? Will they be attractive for western countries? Or will they go for much higher wages in International NGO's working in South Sudan? All these issues are probably highly influencing their decisions.

(iv) **Recruitment of students.** The viewpoint of putting all efforts into the RN/RMW was highly contested among stakeholders responsible for educations at the training institutions. Their argument was mainly linked to the **poorly developed system of primary and secondary education** in South Sudan. Because of the civil war, generations of South Sudanese have not had access to education and still there is a lack of secondary school options in many parts of the country, especially secondary schools including science subjects. The consequence of this is that it may be difficult to recruit students with the required background for the diploma courses (RN/RMW). According to our informants many compromises and modifications are made on the ground. One of them is to ignore the intake criteria's and recruit students without the correct background (such as students with arts background from secondary school or lower marks than required). Another strategy is to maintain to give foundational courses (in language and science subjects) although the GRSS-MOH does not support it. An opinion raised by many of the stakeholders we interviewed both in training institutions and NGO's is that the current HRH training policy will not solve the problems because it is putting too much weight on the registered nurse/midwives level.

Several informants raised the problem of false papers. According to the information we received, many of the applicants presented fake documents from secondary school and this became detectable during the foundation course or early in the first year. This was another argument to maintain the foundation courses according to our informants in the training institutions.

4.3 The current situation and problems in the existing pre-service training institutions in South Sudan

All the issues discussed so far affects existing pre-service training institutions for nurses/midwives greatly and were addressed as matters of concern at all the institutions we visited. However in this subchapter we will discuss some aspects regarding quality of the infrastructure and teaching at the training institutions.

(i) **Infrastructure.** According to the table at page 24-25 there are existing educational institutions for training of nurses/midwives in all states of South Sudan. The condition and state of these institutions regarding infrastructure is though very divers. The experience the assessment team obtained from the field visits displays the extremes of

the picture, from very weak schools consisting of a single room maid of soil (state-owned Torit Nursing School), till upgraded campuses with up to date equipment and all types of relevant facilities (private owned Catholic Health Training Institute in Wau). The MOH has a plan for renovation and construction of infrastructure, but according to our information the needs are enormous and the allocated recourses are inadequate. The plans and timetables presented in the plans (HSDP) seem not to have been followed, and several planned projects have been postponed due to lack of resources. According to our information construction of buildings in particular in some of the states can be is correlated to high risk and extraordinary costs due to soil problems and lack of locally available building materials.

(ii) **The quality of teaching.** The duration of the field visits did not permit for the assessment team to do profound analysis of the quality of the teaching in the training institutions we visited. However the information we have give reason to some suspicions that the quality may differ quite much from one school to another and that the learning conditions for the students is not always the best. The curriculums have apparently weaknesses and are not always adapted to realities on the ground and do not always emphasize the learning outcomes needed to strengthen South Sudanese health service delivery. The *implementation* of the curriculum is nevertheless probably a far more pertinent problem. One reason can be lack of teaching and learning equipment and infrastructure in some of the training institutions (such as Torit). Another issue is the competence of the tutors. The experience that some tutors had received their training 20-30 year ago in Khartoum and has received no refresher course ever since, indicates problems in the delivery of the curriculum at least at some of the training institutions. A significant problem in all the institutions we visited (at least outside Juba) was the quality of the clinical training of the students. There is a severe shortage of trained health professionals at all levels in South Sudan including nurses and midwives, doctors and lab technicians. This affects very much the supervision and guidance the students get when they are out in the clinical placements that constitute a very important part of the training. The lack of qualified nurses/midwives in the hospitals, clinical and PHCUs were of great concern to several of the persons we interviewed.

(iii) **Recruitment of tutors.** Currently there are not very many qualified South Sudanese nurse/midwife tutors. The training institutions we visited display the problem clearly. Most of the tutors were recruited from outside South Sudan mainly from Kenya, Uganda and other neighboring African countries. Several of them had short contracts and planned to stay in South Sudan for just a short period of time (some years). This creates a quite unstable situation for the training institutions and makes long term planning difficult. According to the information we received, the use of NGO/UN seconded volunteers as teachers has some negative side effects related to payment. NGOs and in particular the UN seem to be inflating the salary system for tutors. According to our information UNFPA pays 4500 US$ per month, while NGOs pay around 2500 US$ per month and what is considered a more normal salary for tutors in South Sudan is far beyond this figure (below 1000 US$ per month). This leads to dissatisfaction in the staff and turnover increases.

The MOH have made some efforts to address the problem of lack of qualified South Sudanese tutors for the nurse/midwife training institutions. Since there is no further education (or BSc) for nurse tutors in South Sudan, potential South Sudanese tutors were sent to Arusha, Tanzania for training. 6 nurse/midwives were sent in 2012 and 9 were sent in 2013 to attend a teachers training program.

The tutor situation in the South Sudanese training institutions points at a more general problem in South Sudan. The efforts often from NGOs, CBOs and international partners to be able to fill gaps and solve immediate problems may sometimes compromise more sustainable solutions.

4.4 The role of relevant stakeholders regarding education of nurses/ midwives

(i**) Lack of implementation of policy frameworks**: Many international partners, donor organizations, INGO's and CBO's are involved in the area on nursing/midwife education. Although the INGOs recognizably have saved countless lives and delivered vital contributions to public health in South Sudan, there are perceptions that they are more or less independent of policy frameworks and mechanisms. To be fair to the INGOs it must be said that working in a fragile state environment as a buffer between expectations of the people towards their government and towards the international donors in their aspirations for "high impact results" is not easy. The dominance of the International NGOs in health service delivery reflects in the fragmented geographical patchwork resulting in *unequal coverage of health systems delivery* The Center for Strategic Studies report in 2012 on the "The state of public health in South Sudan" describes current health service delivery system as seriously *supply driven* rather than *demand driven*[3] where the INGOs more or less pick and choose according to their own priorities for engagement.

(**i) Lack of coordination**. There is a lack of coordination of all the partners involved in education of nurses/midwives both at national level and at state level. The existing coordination mechanisms in the health care sector such as the Health Clusters at national and state level, the Health Clusters at national and state level and the NGO – Forums are all focusing on coordination of activities related to health service delivery and not to capacity development.

(ii) U**nequal standards of training and categorization of personnel** as a result of the dominance of INGOs in service delivery health programmes. An example of this can be found in a 2012 overview of results of the then Basic Services Fund where the majority of number of facility based deliveries supported by this financing mechanism were termed as "unskilled" in view of GRSS policy guidelines.

(iii) C**apacity drainage from national health delivery systems** remains as an issue. This again boils down to harmonization of salary scales, inclusion of incentives and implementation of policies of all health personnel being on government payroll.

[3] The State of Public Health in Sudan, Center for Strategic and International Studies, November 2012

(iv) **The line between emergency relief and development** is often blurred in South Sudan (Downie 2012). This is partly due to a continuing lack of stability in parts of the country, and that emergency situations occur and need attention and resources. However the assessment team remained with an overall impression of considerable difficulty of the external aid architecture to move from a predominant historical "well-functioning" conflict and emergency mode to a mode more consistently in line with the key objectives of the principles of the Aid Strategy. Many of the rhetorical expressions we encountered were in support of the Aids Strategy and several mechanisms we encountered were definitely aligned to the extent possible, but still the transformation from one approach to another seems to be difficult.

(v) The assessment team noted some observations in relation to the financing and coordination mechanisms of health service delivery;

- There is a trend, predominantly perhaps as a result of the **austerity budget** crisis that has forced donors to scale down ambitions of health care systems development at the expense of pure health service delivery. The mode of operation is very service delivery minded in which the historical emergency health delivery mode dominates. There seems to be little health systems capacity development alignment, nor standards discussions ongoing within the 3 broader health delivery financing mechanisms.
- There is seemingly **little coordination** or reflection across the "fault line" of key actors in support of midwife/nursing training (CIDA/UNFPA-Ref chapter 3.2) and the broader health care service delivery financing mechanisms.
- Although the churches, and especially the Catholic Church are key National Health Service delivery agents (e.g in Eastern Equatoria the Catholic Diocese of Torit delivers as much as 70% of health services in the state) they have difficulties in accessing funds from the external financing mechanisms. Furthermore they seem not to be active participants in health policy advocacy issues beyond information sharing and delivery coordination at the state and county level cluster meetings. They seem not be active at national level policy level health systems capacity development discussions.

4.5 Using methodology from the Malawi-project in South Sudan

The assessment group believes that many of the experience gained during NCA involvement in nurse/midwife education development can be relevant to the development of a project in South Sudan**.** It is important though to take into consideration the differences between the two counties. One important difference is the **absence of a CHAM equivalent in South Sudan**. CHAM constitutes and umbrella organization coordinating and harmonizing the training institutions run by a diversity of CBOs in Malawi. Another important difference is that the health policy systems in South Sudan are still quite week with lack of well-functioning regulatory systems so far. The enormous challenges and needs as well as the presence of UN and other weighty stakeholders within the area of nursing/midwife education in South Sudan are arguments against a NCA involvement with a comprehensive approach like the project

in Malawi. However many of the experiences from Malawi could be very relevant within a more limited scope, for instance if NCA could concentrate on developing a project in one state. Several experiences from Malawi could be very useful, such as:

- **Infrastructure development: T**he experiences from planning, construction, maintenance etc.
- **Capacity building of educators:** The partnership model in capacity building of tutors in the colleges focusing quality education (curriculum implementation, teaching and learning methods, clinical and skills lab teaching, literature/library resources, evidence based knowledge and information literacy). **Both Norwegian and Malawian Colleges** could have a role as partners in such a project.
- **Capacity building of management:** The experience from focus on strengthening of local management and sense of responsibility of the leaders at the colleges.
- **Strengthening professional organizations.** Collaboration between the developing professional organization in South Sudan and sister-organizations in Norway and Malawi could be vital to sensitization activities in areas like gender, Human Rights and also related to raise the status of the profession and hence aspects like motivation/retention.
- **The experience from facilitating collaboration between stakeholders involved in nursing/midwife education at state level** (such as State MoH, NGOs academics, professional organizations etc).

4.6 Building on NCAs experience and current program in South Sudan

A specific trait of NCA is long term commitment offering solid understanding of local context, relation building and trust over time coupled with flexibility to adapt rapidly to changing circumstances. In South Sudan this represents added value as NCA has a strong and consistent record of delivery and flexibility. Chapter 1.3 spells out some of the most important learnings. In this sense NCA is not just "another NGO" but carries the weight of institutional learning through a more than 40 year history.

The current health program of NCA has a *key objective of reduction of maternal and child mortality*. It is geographically focused to Eastern Equatoria and Warrap states. The program seeks to link service delivery, mobilization and advocacy through;

- Training of community midwives and health workers, rehabilitation of health facilities
- Support church and local government immunization campaigns and essential drug programs
- Training of Village Health Committees with the aim of communities taking increased responsibility for own health
- Capacity development of church partners and local government within national health policy frameworks.

In 2012 an external evaluation of the NCA supported health program was conducted. Extracts from this evaluation that are relevant as reflections into this assessment are;

- Increase focus, prioritize and set realistic expectations.

- Programme design needs to produce greater appreciation for the constraints that characterize post-conflict settings
- Improving women's health and children under 5 access to basic health should be a top priority
- Maintain geographical focus.
- Design a capacity empowerment for local partners
- Collaboration between MoH and faith based actors need to be improved to clarify distribution of future roles and responsibilities.
- NCA and partners need to consider the long term context and to secure their interventions are connected with future services and health funding strategies. The possibility for forming alliances should be maximized

A key learning from the evaluation remains that the health needs in South Sudan cannot be adequately met by short term, localized, project specific and relief focused interventions. The widespread structural deficit can only be met by working on a systemic and long term basis and to scale up aid interventions from local projects to national policies.

The added value potential for NCA in this is the ability to translate acquired knowledge and trust into an approach which facilitates linkages between communities and health actors at all levels. NCA has demonstrated ability to create programmatic connectivity between levels of engagement in the form of facilitation of capacity development and brokering of linkages between health systems and actors at various levels as well as active networking and alliance building between knowledge resources and actors within the health systems.

An envisaged inclusion of nurses/midwives training needs to be viewed in relation to the institutional profile and perceived added value. In our view a profile of midwife/nurses training with a focus at national level would represent an expansion that would represent a significant delink towards the present profile of building "capacity from below". A more conducive line of thought that would secure consistency in the NCA strategic profile would be to envisage expansion into a nurses/midwife training program with a focus on;

(i) Support to the establishment of a state level nurses/midwife training institution in Eastern Equatoria with Torit hospital as a base and the church and government health delivery systems as potential recruitment bases and satellite centers for practical training.

(ii) Support to the existing Catholic training institutions in Wau as a base to include recruitment from the NCA supported health facilities in Warrap state as recruitment bases and satellite centers for practical training. This would need to be seen in view of continued sustainable support from CIDA/UNFPA to the existing state run midwife training college in Wau.

This expansion would in our view build on the current program profile while providing significant potential to harvest from the experiences gained both from the NCA supported training program in Malawi as well as from the contextual historical learning of NCA in South Sudan.

5. RECOMMENDATIONS

5.1 Recommended key activities

Based on the findings and the discussion above the assessment group recommends that NCA builds on the experiences from Malawi and transform/adapt them to design a dual state approach through;

1. Support the establishment and development of a MOH owned and run nurses/midwife training institution in Eastern Equatoria using Torit Hospital as a base and the existing church and government health facilities as recruitment bases and satellites for practical training

2. Support the continued expansion of nurses/ midwife training in Wau through the existing Catholic Church training institutions to include recruitment from Warrap state health facilities. This support would need to be aligned with continued sustainable support from CIDA/UNFPA to the existing state run midwife training college in Wau.

3. Contextualize experience gained from the Malawi program into programmatic support in South Sudan for nurses/midwife training with a focus on

- Infrastructure development
- Capacity building of educators
- Capacity building of management
- Strengthening professional organizations
- Facilitation of collaboration and between stakeholders involved
- Link peer to peer collaboration between Norwegian and South Sudanese nurses/midwife institutions and professional organizations

5.2 Key recommendations for process

The assessment team recommends the elaboration of a stepwise approach:

- Anchor the assessment study and its recommendations with relevant MOH stakeholders at national and state level as well as within key church partners in South Sudan to secure ownership
- Investigate Government of Norway (Embassy and Norad) willingness to accompany an envisaged expansion as indicated above
- Establish a project group in South Sudan involving key stakeholders in South Sudan and with linkage to Norwegian/Malawian network
- Elaborate a project plan and apply for funding in November 2014.

5.3 Key frameworks that should inform the process

- The initiative must reflect on the Aid Strategy for the Government of South Sudan and ensure compliance with key directions of the Norwegian government's endorsement of the "G7+ New Deal for Building Peaceful States" which represents a crucial foundation to enable progress towards the MDGs and to guidance towards international engagement in fragile and conflict-affected states.

- The MoH Health Sector Development Plan 2012-2016 needs to be regarded as the key policy framework guiding the initiative
- The initiative must be informed by the respective strategies and development plans for Eastern Equatoria and Warrap states in terms of health sector development and training.
- The initiative must be solidly anchored within the framework of the 2011-2012 White Paper nr 11 (Stortingsmelding) on Global health in foreign and development policy. The chapters 4.2.3 and 4.2.4 on health systems and health workforce offer policy guidelines
- The initiative should be seen as synchronized with the current internationally supported programs of UNFPA and WHO within health sector training in South Sudan.
- It could be wise to investigate the potential linkages to NORHED as an expansion of collaboration between Norwegian universities to include Norwegian universities and colleges of nursing and midwifery.

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- Special gratitude goes to the principals at the various training institutions for receiving us with hospitality and allowing us to access the information and required.

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ANNEXES

ANNEX 1

Meetings – needs assessment South Sudan

Date	Organization	Name	Team NCA
JUBA			
Tuesday 3rd Sept	Director general for Training, Ministry of Health	Dr. Gabriel Gatwech	Haldis Kårstad, Bodil Tveit, Odd Evjen, Lucia Buyanca
Wednesday 4th Sept	Chief Nurse Ministry of Health	Mrs. Janet Micheal	Haldis Kårstad, Bodil Tveit, Odd Evjen, Lucia Buyanca
Wednesday 4th Sept	Meeting with principal of Juba College ,	Petronilla Wawa	Haldis Kårstad, Bodil Tveit, Odd Evjen, Lucia Buyanca
Wednesday 4th Sept	Medical director of International Medical Corps (IMC)	Dr. Naseer Muhammad Nizamani and assistant	Bodil Tveit, Odd Evjen
Wednesday 4th Sept	AMREF	Country Director Dr.George Bhoka	Haldis Kårstad, Lucia Buyanca
Wednesday 4th Sept	UNFPA	Dr. James Wanyama, Ms.Gillian Burnet	Haldis Kårstad, Bodil Tveit, Odd Evjen, Lucia Buyanca
WAU			
Thursday 5th Sept	MOH		Bodil Tveit, Odd Evjen, Ayen, Madut
Thursday 5th Sept	WAU School of Midwifery IMC compound	Rose Kimali	Bodil Tveit, **Odd** Evjen, Ayen, Madut
Friday 6th Sept	Mary Help Training centre for nurses and health workers	Sr. Gracie	Bodil Tveit, Odd Evjen, Ayen, Madut
Friday 6th Sept	Catholic Health training Institute	Sr. Dorothy Dickson	Bodil Tveit, Odd Evjen, Ayen, Madut
Friday 6th Sept	PHCC	staff	Bodil Tveit, Odd Evjen, Ayen, Madut
Friday 6th Sept	PHCU	staff	Bodil Tveit, Odd Evjen, Ayen, Madut
TORIT			
Thursday 5th	NCA Office	Kasio Luka Moria Janet	Lucia Buyanca, Haldis Kårstad
Thursday 5th Sept	Deputy Governor's Office	Jerome Surur Dr.Margaret Itto Dr.Elija Lomoro	Lucia Buyanca, Haldis Kårstad
Thursday 5th Sept	Torit State Hospital	Dr.Jerry Oleha,Rosemary IUNV	Lucia Buyanca, Haldis Kårstad
Thursday 5th Sept	Torit Nursing and Midwifery School	Principal Pacific Loromo Mathew Ohima	Lucia Buyanca, Haldis Kårstad
Thursday 5th Sept	Merlin (health cluster lead)	Dr.Willy Tabu-Merlin Dr. Sarah Kasoga-County Health Coordinator	Lucia Buyanca, Haldis Kårstad
Thursday 5th Sept	Deputy Governor (dinner at Hotel Torit)	Jerome Surur Dr.Margaret Itto	Lucia Buyanca, Haldis Kårstad
Friday 6th Sept	MOH	Dr.Maragret Itto Dr.Elija Lomoro	Lucia Buyanca, Haldis Kårstad
Friday 6th Sept	Torit State Hospital	Rosemary IUNV Doreen-midwife	Lucia Buyanca, Haldis Kårstad
Sat 7TH Sept	CDOT-PHCU,Magwe	Alvin Agar-Enrolled Nurse	Lucia Buyanca, Haldis Kårstad
JUBA			
Monday 9th Sept	NPA	Dr. Garbing Camera Deputy Country Director	Bodil Tveit, Odd Evjen, Lucia Buyanca, Haldis Kårstad
Monday 9th	WHO	Dr. Suzie Francis Paul	Lucia Buyanca, Haldis

Sept			Kårstad
Monday 9th Sept	Norwegian Embassy	Christine Beate Knudsen First Secretary	Haldis Kårstad, Bodil Tveit, Odd Evjen, Lucia Buyanca, Wilfred
Monday 9th Sept	CIDA, Canadian Embassy	Nancy Belhocine	Bodil Tveit, Odd Evjen,
Tuesday 10th Sept	MOH, final meeting	Dr.Gabriel Gatwech Eve Jagusiewicz Management Development advisor	Haldis Kårstad, Bodil Tveit, Ayen, Lucia Buyanca,
Tuesday 8th Sept	Health Cluster	Dr.Julius Wekesa	Odd Evjen

ANNEX 2 - A brief analyze of the curriculum for diploma midwifery

The curriculum for diploma midwifery was developed in July 2011 by GRSS-MOH with participation and technical support from several partners and stakeholders including nursing and midwife tutors from South Sudan, nurse/midwives educators from East, Central and Southern African College of Nursing (ECSACON) and representatives from International Confederation of Midwives (ICM). A large group of donors and NGOs contributed as well such as UNFPA, WHO, UNICEF, IMC; AMREF and AAH-I (all of them acknowledged in the foreword of the document).
The document is currently undergoing a revision. It was difficult for the assessment group to depict the concrete areas for change and revision and also to find out if the planned revision was major or minor. The curriculum is designed in accordance with the Essential Competencies for basic Midwifery practice, established by ICM in 2010.

In the introduction section of the curriculum, a programme philosophy is described underlining the important objective that the education programme is meant to be closely linked to the needs in the community and that both practice and theoretical education will be both hospital and community based. "Without a community basis to her/his training the future midwife risks being unable to grasp the realities of her clients' lives" According to the curriculum most practical clinical experience will take place in the community and primary health facilities. The goal is to prepare professionally competent and versatile midwifery practitioners who are capable of providing high level SRH and neonatal care to individuals and families in homes, communities, health centres, hospitals and clinics in the rural and urban centres of the society.

Entrance requirements:

- Minimum age of 18 years
- Maximum age of 35 years
- South Sudan certificate of Secondary Education with an average of 60% pass in science subjects (Biology and chemistry and either Physics or Maths). In addition the students should have a pass in English language –
- Equivalent educational background from Kenyan, Ugandan or Ethiopian Secondary Education.

An entry test will be required to assess literacy skills and comprehension, including English language skills, mathematics ability and intelligence test.
The 3- year program includes 30 courses of which 7 are courses in general subjects (such as communication and study skills, psychology, sociology, microbiology, IT, research and management), 7 courses is in basic Midwifery subjects (such as) and 16 are courses in Professional Midwifery (such as
Total hours 3880 hours:

- 1st year includes 1280 hours of which 520 hours are practical hours and 760 hours are theory hours. theoretical
- 2nd year includes 1320 hours of which 880 hours are Practical Hours and 440 hours are theory
- 3rd year includes 1280 hours of which 1000 hours are Practical Hours and 280 Hours are theory

ANNEX 3 - A brief analyze of the curriculum for enrolled midwifery

The curriculum for enrolled midwifery was developed in October 2011 by GRSS-MOH with participation and technical support from exactly the same group of partners and stakeholders as the Curriculum for Diploma Midwives (see above).
At first view the curriculum seem to be a carbon copy/duplication of the curriculum for diploma midwives. The table of content is exactly the same, the reference material is similar. The introduction, programme philosophy, curriculum foundation and programme goals, core values, competencies (page 8-15) are all exactly the same with one exception: Enrolled midwives are not supposed to develop into effective managers of a caseload and of health facilities as is the diploma midwives (Curriculum for Diploma Midwives, Page 13). There are just a few differences between the two programmes in learning outcomes as the Enrolled Midwives are not supposed to:

- Manage the operation of SRH units/health facility sections
- Identify and manage obstetric and new-born emergencies and complications
- Conduct research on SRH issues affecting adolescents, women, men and children
- Managing SRH and neonatal care within the framework of the national health policy
- Supervise student midwife/other health workers in SHR and neonatal services
- Contribute to the formulation of SRH plans and policies

However the enrolled midwives have a couple of learning outcomes in their curriculum that is not present in the curriculum for Diploma Midwives:

- Provide high quality family planning service including long acting family planning methods
- Provide high quality post abortion care including management of post abortion complications and post abortion family planning.

Entrance requirements for enrolled Midwives are exactly the same as for Registered Midwife programme except that the certificate of Secondary Education should have a minimum average of 50% pass (instead of 60%) in science subjects (Biology and chemistry and either Physics or Maths).
Also the requirements for clinical experience differ a bit, but not much. One example is that the RM are supposed to conduct 50 normal deliveries, while the enrolled midwives are supposed to conduct only 40 normal deliveries.
The 2 ½- year program includes 26 courses of which 5 are courses in general subjects,9 courses is in basic Midwifery subjects and 12 are courses in Professional Midwifery
Total hours 3300 hours:

- 1st year includes 1300 hours of which 580 hours are practical hours and 720 hours are theory hours.
- 2nd year includes 1320 hours of which 880 hours are Practical Hours and 440 hours are theory.
- 3rd year includes 680 hours of which 500 hours are Practical Hours and 180 Hours are theory.