ACCESS TO HEALTH FOR SURVIVORS OF CONFLICT-RELATED SEXUAL VIOLENCE IN SOUTH SUDAN

MAY 2020

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January 2018 to January 2020
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# of CRSV victims
1-5
5-10
10-20
20-50
100+
* Final status of Abyei has not yet been determined.
* The boundaries of the map do not imply official endorsement by the United Nations.
N
0
100
200 km

Acronyms

BHI	Boma Health Initiative
CMR	Clinical management of rape
CRSV	Conflict-related sexual violence
HPF	Health Pooled Fund
HRD	Human Rights Division
NAS	National Salvation Front
NGO	Non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Post-exposure prophylaxis
PHCC	Primary health care centre
PHCU	Primary health care unit
R-ARCSS	Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SPLA-IO/RM	Pro-Machar Sudan People's Liberation Army in Opposition
SSNPS	South Sudan National Police Service
SSPDF	South Sudan People's Defence Forces
STI	Sexually transmitted infection
UNMISS	United Nations Mission in South Sudan
WHO	World Health Organization

I. Executive summary

1. In May 2018, Esther[1], a 40-year-old mother of five, was one of many women and girls who were gang-raped as they attempted to flee their village in Leer county, Unity state. Since then, she has been trying to rebuild her life while battling physical injuries, chronic pain, and psychological trauma. As she told human rights investigators of the United Nations Mission in South Sudan (UNMISS), her ordeal did not end after the rape was over:

> ***The only support I need is to improve my health. Without health, nothing is possible****… but the health facility is always running out of medicine, and I cannot buy medicine when my children are starving. There is no work for me in town, and I do not make enough money with the small firewood I am able to collect, and I cannot carry as much firewood now as I did before the rape, because of the pain in my body. We are now forced to depend upon others.*

2. This report tells the story of survivors such as Esther, who have been struggling to access adequate medical care, and of health care workers endeavouring to provide such care, in a country torn apart by a devastating armed conflict, despite the presence of major international actors supporting the health care sector.[2] It is based on the findings of an investigation by the UNMISS Human Rights Division (HRD) conducted between January 2018 and January 2020, and focuses on nine counties in Central Equatoria, Unity and Western Equatoria states, where the highest incidence of conflict-related sexual violence (CRSV) was documented during this period.

3. Since 2013, sexual violence has been a widespread and pervasive feature of the conflict in South Sudan. While the number of reported CRSV incidents have decreased overall since the signing of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS) on 12 September 2018, CRSV and its after-effects have nonetheless persisted well beyond the suspension of major hostilities. Myriad reports from UNMISS, human rights organizations, health service providers, and journalists have documented the ordeal of survivors, who have been subjected to appalling acts of sexual violence[3] and suffered long-term physical harm and mental health consequences.

4. The victims must find a way to survive, and returning to work and resuming a normal life is critical for their sake and that of their families, sometimes even before initiating any legal action.[4] In this respect, ensuring access to immediate and adequate medical care, including confidential sexual and reproductive health care, in order to prevent further physical and psychological deterioration constitutes a crucial first step towards rehabilitation, as well as a form of social accountability. It is also a fundamental human right.

5. In accordance with international human rights law, [5] South Sudan shall ensure and provide access to appropriate heath care for victims of sexual violence, to the maximum extent of its available

[1] The names of all individuals quoted in this report have been changed to pseudonyms for protection purposes.
[2] This report is jointly published by the United Nations Mission in South Sudan (UNMISS) and the Office of the United Nations High Commissioner for Human Rights (OHCHR), pursuant to United Nations Security Council Resolution 2459 (2019).
[3] While human rights violations and abuses have largely decreased in the country since the signing of the Revitalized Agreement on the Resolution of the Conflict in South Sudan (R-ARCSS) on 12 September 2018, the incidence of conflict-related sexual violence (CRSV) has persisted. Between January 2018 and January 2020, UNMISS documented 356 incidents of CRSV involving at least 1,423 victims, including 302 minors.
[4] In addition to the fact that victims rarely seek justice or obtain redress through the formal justice system, which is unable, ill-equipped and occasionally unwilling to address these cases.
[5] *See infra* Annex 1 for an analysis of the legal framework on the right to health.

resources. Nevertheless, HRD found that the Government has not sought to make funding of the public health sector a priority. For the 2019-2020 fiscal year, 1.2 per cent of the national budget was allocated to the entire public health sector, amounting to approximately USD 14 million.[6] This contrasts sharply with the USD 20 million allocated for the health care of the members of the national legislature during the same fiscal year.[7]

6. The lack of support from the Government to the public health sector has led to the *de facto* outsourcing of health care services to international organizations and reliance on international donor funding.[8] However, due to the protracted humanitarian crisis and competing donor priorities, international organizations, and in particular United Nations agencies, have faced significant challenges in aligning their programmes to address the structural and functional shortcomings of South Sudan's facility-based health care system in a context marred by weak economic governance structures and low government budget credibility.[9]

7. Some international and faith-based organizations have attempted to overcome accessibility challenges by initiating *ad hoc* mobile clinics, "one-stop" centres and awareness-raising programmes to reach out to local communities, or by supporting the Government's community-based programme, the Boma Health Initiative (BHI). However, these programmes carry their own set of obstacles, including limited outreach and lack of confidentiality, which limit the ability of survivors to benefit from their services.

8. Overall, despite the major financial investments made by international organizations in the health care sector, the medical response for victims of sexual violence remains weak, particularly in nine counties[10] in Central Equatoria, Unity, and Western Equatoria states, which accounted for 85per cent of all cases of CRSV documented by HRD between January 2018 and January 2020.

9. The lack of Government funding, coupled with the inability of international organizations to make the medical response to sexual violence a priority, have contributed to an inadequate medical response for survivors. In addition, HRD identified three other major challenges preventing victims from accessing health care facilities, goods and services, and hindering public health workers in delivering adequate medical care.

10. The first challenge is linked to the spatial accessibility of health care facilities. HRD found that the number of functional facilities in CRSV hotspots largely falls short of World Health Organization (WHO) standards (at least two per 10,000 persons)[11] and the Ministry of Health's own commitment

[6] Based on an official exchange rate of 161 South Sudanese pounds (SSP) to one USD.
[7] Republic of South Sudan, Ministry of Finance and Economic Planning, FY 2019/2020 Approved Budget Book, *available at:* http://www.mofep-grss.org/docs/fy-2019-2020-approved-budget-book/. The calculation of USD 20 million is based on an allocation of USD 50,000 per legislator, based on a membership of 400 legislators at the national level. In February 2020, half of the allocated amount was distributed to members of the legislature, drawing public criticism. *See, e.g*., Elsheikh Chol, "Advocate criticizes financial offer to MPs", Eye Radio (2 Mar. 2020), *available at:* https://eyeradio.org/advocate-criticizes-financial-offer-to-mps/.
[8] Based on HRD's calculations, the Government's budgetary allocation of USD 14-15 million constitutes between 8 and 9 per cent of the minimum budget (USD 167 million as estimated by HRD on the basis of available data) needed to sustain the public health care system in fiscal year 2019/20. More than 90 per cent of funding is provided by international donors.
[9] *See, e.g.*, UNICEF, *National Budget Brief: South Sudan 2019 (May 2019)*, *available at*: https://www.unicef.org/southsudan/reports/national-budget-brief. Budget credibility refers to the extent to which a government meets its revenue and expenditure targets during a given fiscal year. When actual spending deviates from the approved budget, it is described as either underspent (if spending is less than what was allocated) or overspent (if spending is greater than the allocation).
[10] Four counties in Unity (Guit, Leer, Mayendit and Rubkona); four in Western Equatoria (Ezo, Nagero, Tambura and Yambio); and one in Central Equatoria (Yei).
[11] At two per 10,000 persons. Ministry of Health, *Service Availability and Readiness Assessment [SARA], Draft Report* (2019).

to having a functioning health facility within 5 km of every citizen's home.[12] HRD determined that in these hotspots, the average number of health facilities stands at 1 per 10,000 persons, with an estimated 72 per cent of the population in these areas living outside of a 5 km radius of the nearest functional public health facility. This inadequate and unequal distribution of health facilities exposes survivors to further risks of harm, due to the long distances they must travel to access medical care. In many cases, they must also travel through areas with a major presence of armed actors.

11. The second challenge pertains to the service readiness of functioning health facilities. Overall, there is a low ratio of skilled health workers in the areas most affected by CRSV as compared with WHO standards. As a result, many survivors are unable to access treatment provided by a qualified doctor, nurse or midwife when reaching health facilities. At the same time, health care workers who are present in these facilities experience hardship conditions at work, including very low and frequently delayed salaries – on occasion resulting in informal payment requests to access healthcare – a lack of equipment and supplies, overwhelming demand and in some areas, ongoing insecurity. HRD also found that the operational capacity of health facilities to clinically manage rape cases is limited. Equally concerning is the limited number of survivors able to access health facilities that have post-rape treatment kits on hand within 72 hours of being raped,[13] with the exception of victims living in main towns and protection of civilians (POC) sites. Indeed, they often seek treatment at health facilities only after developing complications, such as sexually transmitted infections (STIs), unwanted pregnancy and complications arising from unsafe abortions.

12. A third major challenge relates to social barriers. The stigmatization of victims of sexual violence, coupled with the risk of being exposed as a survivor in seeking out health care, has compelled many to suffer in silence, with limited access to mental health care or psychosocial support. HRD investigations also confirmed that the capacity of the health system to provide mental health care, though critical in addressing trauma resulting from sexual violence, is nearly non-existent. Mental health care has not been considered as a high priority by Government actors or international partners.[14]

13. Prospects for victims in accessing adequate medical care will remain bleak for the foreseeable future, in the absence of drastic changes in the Government's involvement in the health sector. South Sudan is already off-track in achieving critical Sustainable Development Goals (SDGs) by 2030, including SDG3 (to "ensure healthy lives and promote well-being for all at all ages") and SDG5 (to "achieve gender equality and empower all women and girls"). It is also critical for international actors to enhance coordination of their health and protection programmes to strengthen the national health system, support local actors and prioritize access to medical care for victims of sexual violence.

[12] Ministry of Health, *Basic Package of Health and Nutrition Services (BPHNS) for Primary, Secondary and Tertiary Health Care in South Sudan* (2019).

[13] Multiple health services providers indicated that after 72 hours, HIV post-exposure prophylaxis (PEP) is generally not provided to survivors, as its effectiveness diminishes significantly.

[14] Nonetheless, there is growing consensus amongst the international community on the need to include mental health and psychosocial support as a core component of humanitarian responses in crisis situations. *See, e.g.*, the Netherlands Ministry of Foreign Affairs, "Mind the Mind Now Declaration" [the "Amsterdam Declaration"] (8 Oct. 2019) (outlining recommendations made by representatives of governments and international organizations to prioritize mental health and psychosocial care in emergencies), *available at:* https://www.government.nl/ministries/ministry-of-foreign-affairs/events/mental-health-and-psychosocial-support-in-crisis-situations/news/amsterdam-conference-declaration.

14. To this end, UNMISS and OHCHR make the following recommendations:

To the Government of South Sudan:

- Substantially increase budgetary allocations for the public health sector above the current 1.2 per cent – considering that in order to meet international targets, 15 per cent of the fiscal year budget should be allocated to the public health sector; and strengthen the capacities of public health facilities and health workers.

- Significantly improve access to and delivery of health services, especially on sexual and reproductive health, on an equitable basis at the community level.

- Ensure that competent national prosecutorial and judicial authorities investigate, prosecute and try individuals bearing responsibility, including those in positions of command and control, for violations and abuses of international human rights law, and violations of international humanitarian law, including CRSV and attacks against medical personnel and facilities.

- Ensure that victims have access to comprehensive programmes addressing immediate and long-term health and psychological needs.

- Conclude the process of accession to the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and their Optional Protocols by transmitting to the UN Secretary-General the respective instruments of accession.

To international donors and partners:

- Strengthen the development, humanitarian and peace nexus, in particular between projects providing medical responses for survivors of sexual violence and programmes addressing structural shortcomings in the public health sector, with regard to sexual and reproductive health care.

- Use existing multi-donor funding mechanisms to support the Government of South Sudan to establish an inclusive, participatory and transparent follow-up and review mechanism to monitor, track and evaluate progress in implementing the SDGs (particularly SDG3 and SDG5) at the national and sub-national levels.

- Support measures to prevent CRSV, including mechanisms to ensure accountability for perpetrators and to raise awareness about CRSV prevention and response amongst parties to the conflict, including through the implementation of Action Plans of the South Sudan People's Defence Forces (SSPDF), the pro-Machar Sudan People's Liberation Army in Opposition (SPLA-IO/RM) and the South Sudan National Police Service (SSNPS) to address CRSV.

To Government, civil society and international actors:

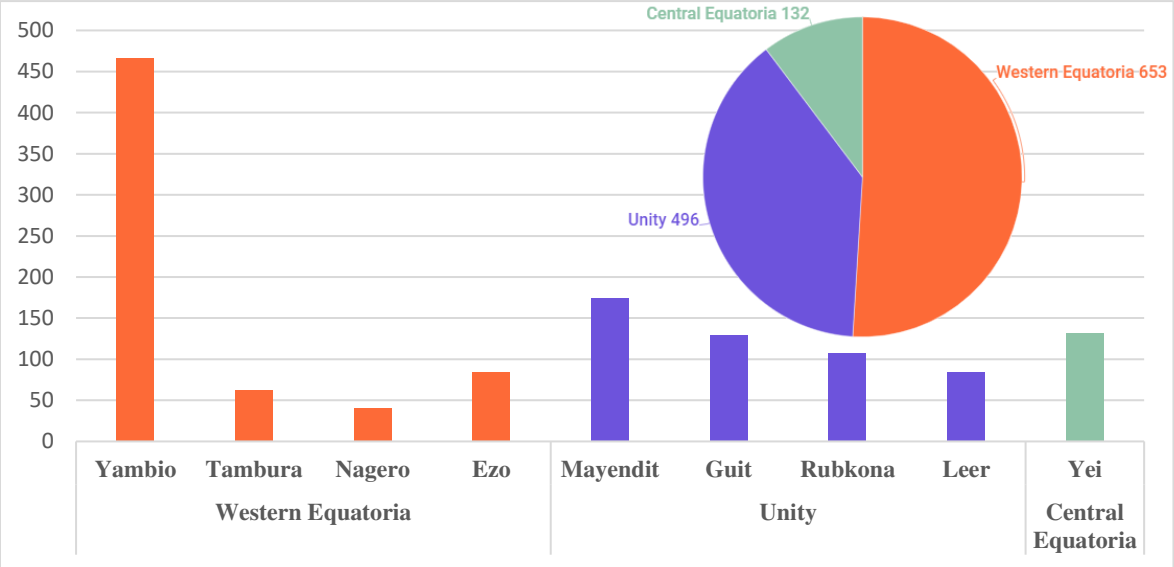
- Increase efforts to overcome social barriers at the national and grassroots levels, through sensitization activities to empower key influencers, such as religious and community leaders, to change social norms contributing to the stigmatization of survivors.

II. Methodology

15. The report contains the findings of a series of investigations conducted by the UNMISS Human Rights Division (HRD) on the medical and psychosocial response provided by public health care facilities and personnel in the areas most affected by conflict-related sexual violence (CRSV) between January 2018 and January 2020.

16. To document and verify the physical harm and long-term mental health consequences resulting from rape, and to identify challenges and barriers preventing victims from accessing functioning health facilities, goods and services, and public health workers from delivering adequate medical care, HRD carried out an in-depth investigation in Central Equatoria, Unity and Western Equatoria states, which were the most affected by CRSV between January 2018 and January 2020. In particular, HRD focused on the nine counties profiled in the table below (four in Unity, four in Western Equatoria, and one in Central Equatoria), where the highest incidence of CRSV was documented. HRD also examined the health care situation in Akobo (Jonglei), which is under the control of the pro-Machar Sudan People's Liberation Army in Opposition (SPLA-IO/RM), as a basis of comparison for areas outside of the Government's control.

Table 1: Number of victims in counties most affected by CRSV, January 2018 – January 2020



17. Information regarding service availability and readiness of health facilities in South Sudan and their capacity to provide basic health care to survivors of sexual violence is derived from investigations by HRD and preliminary information obtained through the country's first-ever Service Availability and Readiness Assessment (SARA).[15]

[15] *See* https://www.who.int/healthinfo/systems/sara_introduction/en/. According to WHO, SARA is a systematic survey designed to generate reliable and regular information on service delivery (such as the availability of key human and infrastructure resources), on the availability of basic equipment and amenities, essential medicines, and diagnostic capacities, and on the readiness of health facilities to provide basic health-care interventions relating to family planning, child health services, basic and comprehensive emergency obstetric care, Human Immunodeficiency Virus (HIV), tuberculosis (TB), malaria, and non-communicable diseases. It should be noted that, at the time of research, South Sudan had been divided into 32 states following presidential orders in 2015 and 2017. However, in February 2020, in furtherance of the implementation of R-ARCSS, a presidential order was issued, returning the country to the 10 original states (Central Equatoria, Eastern Equatoria, Jonglei, Lakes, Northern Bahr el Ghazal, Unity, Upper Nile, Warrap, Western Bahr el Ghazal and Western Equatoria). Where possible,

18. To complement SARA, HRD used a 2017 study carried out by international academic researchers from the Kenya Medical Research Institute, on spatial accessibility to basic public health care facilities in South Sudan,[16] in order to establish the distance separating victims of sexual violence from health facilities in the counties most affected by CRSV. HRD also obtained information on the current functionality of health facilities from actors in the health sector and during on-site visits to at least 26 facilities in the profiled counties.

19. In total, UNMISS human rights officers interviewed more than 248 individuals in the preparation of this report, including 113 survivors of sexual violence (103 women, 10 men), as well as medical and psychosocial service providers, local and national administrative authorities, and other relevant actors. Furthermore, HRD organized six focus group discussions amongst women and survivors in three locations to corroborate local perceptions of available health services in the targeted areas. In some cases, HRD interviewed survivors who experienced CRSV prior to the reporting period of January 2018-January 2020, to illustrate the longer-term impact of sexual violence on survivors' physical and mental health.

20. HRD encountered several challenges in the course of investigations, including the high mobility of the population, as many of the survivors have been displaced or returned to their places of origin since they were attacked, and are not easily traceable. HRD has also attempted to present rich, detailed accounts of incidents and the professional experiences of health workers, while ensuring that the confidentiality of sources was maintained. In accordance with the "do no harm principle" of OHCHR methodology, human rights officers ensured that all appropriate protocols were applied prior to, during and after interviews, for the protection of sources. All names have been changed to protect the confidentiality of the sources, and in the case of health workers, all geographic identifiers have been omitted for those who wished to remain anonymous.

21. HRD employed the *reasonable grounds to believe* standard of proof in making factual determinations as to violations, abuses, incidents and patterns of conduct documented in the report, and gathered information in accordance with the human rights monitoring and investigations methodology developed by OHCHR. In cases where survivors had not received medical or psychosocial support, UNMISS human rights officers referred them to appropriate service providers.

III. Context

1. Overview and scope of conflict-related sexual violence in South Sudan

22. Since the outbreak of the armed conflict in December 2013, civilians have borne the brunt of violence in South Sudan. While conflict-related violations and abuses, including sexual violence, have largely decreased since the signing of the R-ARCSS on 12 September 2018, rape, gang rape, sexual slavery and forced marriage, which were common features of attacks targeting civilians during active hostilities involving parties to the conflict, have persisted.

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adjustments have been made to reflect this development. However, in the case of SARA and other studies, which disaggregate data based on the 32-state model, this has not been possible. In such cases, these states are referred to as "former" states.

[16] Peter M. Macharia, Paul O. Ouma, Ezekiel G. Gogo, Robert W. Snow and Abdisalan M. Noor, *Spatial accessibility to basic public health services in South Sudan*, Geospat. Health 2017 May 11, 12(1); 510 [hereinafter "Spatial accessibility survey"], *available at:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483170/. The survey utilized advanced spatial analysis techniques, including the measuring of Euclidean distances through satellite images; various shape files; as well as datasets from the National Aeronautics and Space Administration (NASA), United Nations agencies and reliable open-source platforms. Additionally, the survey has been cited by numerous academics and institutions, including the US National Institutes of Health (NIH).

23. Between January 2018 and January 2020, UNMISS documented 356 incidents of CRSV involving at least 1,423 victims.[17] Most of these incidents occurred in Central Equatoria, Unity and Western Equatoria, and the majority (more than 85 per cent) occurred in 2018. The victims included pregnant women, lactating mothers, elderly women, girls as young as four years old, as well as men and boys. Of these 1,423 victims, 302 were confirmed as children. In some areas, several survivors recounted having been raped multiple times in separate incidents over the past few years. Throughout the conflict, responsibility for incidents of CRSV is spread amongst Government and opposition forces. Proxy armed elements, including (clan-based) youth militias used by parties to the conflict to support their offensives, have also been major perpetrators of sexual violence.

24. In the context of South Sudan's armed conflict, sexual violence has been used as a weapon of war to humiliate, terrorize and tear apart the social fabric of families and communities, to forcibly displace civilians, and to inflict individual and collective trauma.[18] Gender-based discrimination and a continued lack of criminal accountability at both the superior and direct perpetrator levels has fuelled this violence, contributing to its normalization in society and further underpinning gender inequality. While women and girls have been the primary targets, men and boys have also been subjected to sexual violence, and HRD took their experiences into account during investigations for this report.

2. Overview of the public health sector in South Sudan

25. At independence in July 2011, the new Government of South Sudan inherited a fragile and, in some areas, virtually non-existent public health care system. Research carried out in 2011 indicated that only an estimated one-third of the population had access to basic health care services.[19] The outbreak of violence in December 2013 worsened the situation.

26. South Sudan's health indicators rank amongst the lowest in the world. In 2018, the average life expectancy was 58 years.[20] The country also has the world's highest maternal mortality ratio, at 1,150 per 100,000 live births.[21] A study released in 2017[22] estimated that nearly 72 per cent of the population lived more than 5 km (equivalent to a one-hour walking distance) from the nearest public health facility.[23] The National Health Policy (2016-2026) recognizes health as a human right and commits to the expansion of access to primary health care on an equitable basis as one of its key objectives.[24]

27. The public health sector relies essentially on a three-tiered, facility-based system to deliver medical care to survivors of sexual violence: at the primary level, primary health care units (PHCUs) and primary health care centres (PHCCs); at the secondary level, county and state hospitals; and at the tertiary level, national, teaching and specialized hospitals. According to the Basic Package of Health

[17] According to UNFPA, the national Gender-Based Violence Information Management System (GBVIMS) documented 723 cases of sexual violence between January and October 2018. During the same period in 2019, it documented 672 cases. It should be noted, however, that GBVIMS does not provide disaggregated data on perpetrators.
[18] *See, e.g.,* UNMISS & OHCHR, *Indiscriminate attacks against civilians in southern Unity, April-May 2018* (10 July 2018); *Violations and abuses against civilians in Gbudue and Tambura states (Western Equatoria), April-August 2018* (18 Oct. 2018); *Conflict-related sexual violence in northern Unity, September-December 2018* (13 Feb. 2019); UNMISS, *Conflict-related violations and abuses in Central Equatoria, September 2018-April 2019* (3 July 2019), available at: https://unmiss.unmissions.org/human-rights-reports.
[19] Macharia et al., *supra* note 16.
[20] UNICEF, *State of the World's Children 2019* (Oct. 2019).
[21] Six other sub-Saharan States have under-five mortality rates ranging from 101 to 122. *Ibid.*
[22] On the basis of 1,446 health facilities regarded as functional around 2016. Macharia et al, *supra* note 16.
[23] The Ministry of Health utilizes data from a national mapping exercise from 2011, prior to the outbreak of the South Sudanese civil conflict, which places this number at 44 per cent.
[24] South Sudan Ministry of Health, *National Health Policy (2016-2026): A Community- Anchored Health System for Sustainable Health Sector Development* (May 2016).

and Nutrition Services (BPHNS), [25] all secondary and tertiary facilities can provide basic post-rape medical care, including the administration of post-exposure prophylaxis (PEP) treatment, while PHCUs should refer cases of sexual assault to PHCCs, which are in principle better equipped to treat victims.

28. In some state and national hospitals, "one-stop" centres have been established to facilitate access to essential services for survivors of gender-based violence. These centres offer medical, psychosocial and legal assistance in a single facility, and employ staff who have received targeted training in the clinical management of rape (CMR), including physicians, nurses, midwives, and psychosocial counsellors. As of January 2020, the United Nations Population Fund (UNFPA) has supported nine "one-stop" centres in Juba, Bor, Kapoeta, Malakal, Malualkon (Aweil), Rumbek, Torit, Wau and Yambio.[26]

29. In 2018, SARA determined that the average number of health care facilities throughout the country (at 1.43 per 10,000 persons) did not meet WHO standards of 2 per 10,000 persons.[27] SARA also found that the ratio of core health workers (6.3 per 10,000 persons) fell far short of the WHO threshold (23 per 10,000 persons).[28]

30. The years of conflict and lack of public funding for the training of core health workers have had a ripple effect on the availability of medical professionals. The country's only medical school (at the University of Juba) has not been adequately staffed or equipped. It offers a programme of study for general medical doctors, but graduates must complete additional study and training abroad in order to specialize in fields such as gynaecology. Several schools of nursing and midwifery established throughout the country[29] have the potential to address some of the shortfalls in core health workers, but State-run programmes are chronically short of funding.

31. Overall, SARA determined that the country's general health service readiness stands at 37 per cent of international minimum standards for the delivery of basic health care services. Moreover, this assessment only measures the availability of services in five key domains[30] for any given health facility, but does address variations in the quality of services available.

32. Readiness for mental health care, which is critical to address trauma resulting from sexual violence, is even lower, and varies significantly in quality. Mental health care has not been considered a high

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[25] According to WHO and the Global Health Cluster (GHC), a "basic" or "essential" package of health services may be defined as "detailed lists of interventions/services (preventive, promotive, curative, rehabilitative and palliative) across different levels of care, endorsed by the government at the national level, or agreed to by a substantial group of actors when services are to be provided in areas outside of government control." Additionally, "these interventions should be available to all, safe, people-centred, and of assured quality to be effective. . . and funded by the government, with or without donor support. . . ." WHO & GHC, *Working paper on the use of essential packages of health services in protracted emergencies* 2 (Feb. 2018), *available at:* https://www.who.int/health-cluster/about/work/task-teams/EPHS-working-paper.pdf?ua=1.

[26] One additional centre is semi-operational in Yei, receiving some support from the United Nations High Commissioner for Refugees (UNHCR). Confidential meeting in Juba, 27 Sept. 2019.

[27] SARA, *supra* note 11. According to information provided by WHO, as of 2018, there were 1,127 PHCUs, 356 PHCCs, and 49 county, state and national/specialized hospitals in South Sudan. Of the 1,483 PHCU/PHCCs included in this list, 200 (13 per cent) were reportedly non-functional. Four county hospitals (two in Central Equatoria (Kajo-Keji, Morobo), one in Unity (Leer), and one in Western Equatoria (Ezo) were also non-functional, while 45 county, state and national/specialized hospitals, including three teaching hospitals in Juba, Malakal and Wau, were functional.

[28] "Core health workers" defined as physicians, nurses and midwives. WHO standards for the number of health care facilities and core health workers per 10,000 persons stand at two and 23, respectively. SARA, *ibid.*

[29] In Juba and Yei (Central Equatoria), Torit (Eastern Equatoria), Yambio and Maridi (Western Equatoria), Malakal (Upper Nile), Wau (Western Bahr el Ghazal), and Rumbek (Lakes). Confidential meetings in Juba, 14 May 2019 and 7 Nov. 2019.

[30] According to SARA, "readiness" is defined as the availability of components to provide services in five domains: (1) standard precautions, (2) basic equipment, (3) basic amenities, (4) diagnostics and (5) essential medicines.

priority by Government actors or international partners. This is evidenced by the minimal resources allocated to mental health care programming, limited essentially to the payment of salaries of a handful of mental health professionals.[31] As of January 2020, there were only three professional psychiatrists practicing in South Sudan, two of whom were employed by private clinics, while the third rotated between Juba, Malakal and Wau teaching hospitals. Thus, psychiatric treatment is only available in the Psychiatric Department of Juba Teaching Hospital, and the psychiatric units of Wau and Malakal Teaching Hospitals. In other public hospitals, health care personnel may be trained to provide basic psychosocial support, including counselling or psychological first aid, but are not mental health specialists and may not prescribe psychiatric medication.

IV. Physical harm and trauma resulting from sexual violence

33. The consequences of sexual violence are often devastating, potentially affecting all aspects of survivors' lives. The following paragraphs highlight the voices of those who have suffered from sexual violence, as well as their family members, case workers and medical practitioners who have provided care or support to survivors. Far from being exhaustive, these accounts provide a glimpse of the clinical impact and long-term mental health consequences resulting from sexual violence.

1. Physical harm

34. The brutality of the violence used by all armed actors while committing rape has frequently caused serious injuries and resulted in major medical complications, particularly among young girls, pregnant women and older women. In some cases, injuries or infections resulting from rape can result in death.

1.1. Death

35. Agnes, a 47-year-old mother of seven children, recounted to human rights officers how she felt fortunate to be alive after being gang-raped by several armed men near Bentiu in December 2018, because she knew a few victims from a similar attack did not survive. She credited her survival to the fact that she was able to access health care shortly after the incident:

> *I am lucky because I am healthy now. Last year, two women and one girl were gang-raped by armed men when they were walking to Bentiu town. . . One of the women and the girl returned to the village after the incident. The other woman went to Bentiu but never visited the hospital because of shame. She became very ill and passed away last month. Her relatives told me she died of an illness that was caused by the rape. The two other survivors [the woman and the girl] have also passed away. . . ."*

36. When HRD spoke with Sarah, a health worker, she was still disturbed by the story of a 16-year-old girl with a cognitive disability, who was gang-raped in July 2019 near a position of the South Sudan People's Defence Forces (SSPDF). She recalled the condition in which she found the girl, who had been previously treated for HIV following an earlier rape, and how health care workers struggled to keep her alive for over two weeks:

> *I noticed a swarm of flies coiling around a human figure, so I went closer and checked. It was the body of a girl dumped in the area. . . she looked so pale, dried out by the sun, with cracked lips. I felt her pulse, I realized she was still alive—barely, but still alive. .*

[31] These professionals do not receive incentives from international funding sources, as other health care workers do (*see infra* Section VIII).

.maggots were already eating her while she was still alive. There was swelling and bruising on her body as well. … [At the hospital], they found that she was raped, maybe by more than one person since two pieces of condoms were found inside her vagina. The girl stayed alive for about two weeks. Each day she was getting weaker. When she died after about two weeks, we arranged her burial.

1.2. Serious injuries and miscarriages

37. Common forms of physical injury from rape encountered by medical practitioners include lacerations, fractured bones, vaginal tearing, and injury to the cervix.[32] In cases of gang rape involving very young women and girls, traumatic fistula[33] (which results in the uncontrolled leakage of urine and/or faeces) and permanent damage to the reproductive organs have also been documented.[34]

Grace, a health worker who was interviewed by HRD in 2018, recounted the case of Elizabeth, a 30-year-old victim who was seriously injured after being raped by five SPLA[35] soldiers in November 2016.

*She was admitted to a county hospital by the farmers that found her in the bush. She was severely bleeding and could not walk by herself. One of the soldiers struck a bayonet to her vagina, also damaging her uterus. She was rushed to the hospital because of the severity of her case. Months later, I saw her again and as we spoke she told me '**I feel so useless. The humiliation and the pain is still all over me and now I can no longer have a child. I wish those soldiers had just killed me after what they have done to me.**' In early 2018, I learned from her neighbours that she was gone, and no one really knows where she went.*

38. Pregnant women have also been subjected to sexual violence during South Sudan's conflict, and are at risk of miscarriage as well as complications, such as hypertension of pregnancy and premature delivery, as a result of rape. HRD spoke with multiple survivors who reported miscarriages following rape.

Nyachual, a 50-year-old woman, recounted how she and her 25-year-old pregnant daughter, Mary, were both raped during the same incident in which eight women were attacked in Unity in 2018, and that Mary suffered a miscarriage as a result of the rape:

*The armed men surrounded all of us and beat us using the butts of their rifles. . . and raped each of us. The younger ones were raped more than once or twice. I feel so sorry for my daughter, who was the youngest amongst us because three men raped her until she started to bleed. We all went to Bentiu and were referred to a clinic the following day by a good Samaritan from the town. **My daughter was continuously bleeding until we were told at the clinic that she lost the baby she was carrying**.*

[32] Damage to and/or infection of the cervix may lead to sterility, however no data is available on this issue in South Sudan. Disabilities resulting from back/nerve damage may also result, but again, no data is available.
[33] The tearing of the lining between the vagina and the bladder and/or rectum.
[34] The majority of cases documented in South Sudan are of obstetric fistula, primarily linked to early childbearing. Data on traumatic fistula caused by sexual violence was not available at the time of reporting. Confidential meeting in Juba, 23 Jan. 2019.
[35] The Sudan People's Liberation Army (SPLA) was renamed the South Sudan People's Defence Forces (SSPDF) in 2018, following the signing of the R-ARCSS.

1.3. Chronic pain

39. Long after the incident, other physical injuries continue to impact the survivor's day-to-day existence. Several survivors reported chronic pain and, in some cases, long-term disability, which prevent them from farming or carrying firewood, water or food rations, although these daily activities are critical for sustaining their families.

40. Rose, a 40-year-old survivor from Unity, was gang-raped in 2019 by four unidentified armed elements while going in search of firewood. She described to HRD some of the continued impacts of the rape:

> *I am still suffering from severe pain in my abdomen. It must be linked to the rape because I never had such issues before. Because of this pain, I cannot make many trips to the bush, and I can only collect small amounts of firewood these days, which means I am making less money than before.*

1.4. Sexually transmitted infection (STI)

41. In interviews with survivors and health care providers, and in focus group discussions with women, human rights officers were repeatedly informed of the high prevalence of HIV, Hepatitis B[36] and other infections resulting from rape. According to medical specialists, the risk of infection is indeed higher in survivors of sexual violence in general, due to the increased likelihood of genital injury and the high HIV prevalence among armed actors. While syphilis may be treated and cured if diagnosed at an early stage, HIV infection requires the survivor to be treated with antiretroviral medication on a continual basis.

> *Francis, a case manager, recounted the situation of Rebecca, a 14-year-old girl who was raped by an SSPDF soldier in June 2018 and later diagnosed with HIV and syphilis. He described how he struggles to find the right words to encourage her:*
>
> *Until now, I am closely monitoring Rebecca, not just for her health issues but to morally support her. The last time I visited her, I came to remind her to take her antiretroviral [HIV] treatment, and was feeling really sorry for her when she told me,* ***'There is no cure for me and I can no longer have a family of my own no matter how much I want to. Perhaps it is better for me to go away where no one knows me, or just kill myself one day.*** *Since I was raped, my friends are all avoiding me.'* ***As her case manager, I honestly find it hard to respond****, but I still managed to tell her not to give up, because as long as there is science, there is hope for a cure for HIV.*

2. Trauma

42. The mental health consequences of rape can be severe and long-lasting. In the context of South Sudan's armed conflict, sexual violence has been used as a weapon of war to tear apart the social fabric of families and communities, and to inflict individual and collective trauma. Mental health and psychosocial support service providers interviewed by HRD reported that many survivors are likely suffering from the untreated symptoms of conditions including post-traumatic stress disorder (PTSD), depression and anxiety. The symptoms of these conditions may include social withdrawal, feelings

[36] Hepatitis B is a viral infection that attacks the liver, which can cause acute or chronic infection, and may result in death if untreated. WHO, *Fact Sheet: Hepatitis B* (18 July 2018), *available at:* https://www.who.int/news-room/fact-sheets/detail/hepatitis-b.

of shame and hopelessness, difficulty concentrating, nightmares, flashbacks, anxiety and panic attacks, and acts of self-harm, including suicide.

> Agnes, a 42-year-old mother of seven in Unity, was gang-raped by three armed men in 2017 in the presence of her husband. When HRD interviewed her in 2019, she recounted the lingering impact of trauma on both herself and her husband:
>
> *Sometimes, **I have flashbacks and become very angry at people for no reason**. . . My husband still feels ashamed, because I think **he feels guilty that he was not able to protect me** from those men.*

43. Male survivors reported that they have extreme difficulty in discussing their experiences, even with their closest family members. HRD spoke with several men who described the heavy burden of bearing their trauma virtually alone. Twenty-seven-year-old Thomas, who was gang-raped alongside his wife by SPLA soldiers in Unity in 2014, described the relentless impact of the attack, more than five years later:

> *I did not see any doctors about my case even though I was in extreme pain after the incident, because I was ashamed and afraid of what people would say. For the physical pain, I was only taking paracetamol. **Until now, the incident is still giving me nightmares and every time I think of what was done to me, I feel weak and sick – I am convulsing as if I have a high fever**.*

44. Similarly, 28-year-old James, who was gang-raped by five SPLA soldiers in Juba in July 2016, told human rights officers that he has been unable to have sexual intercourse since then, as attempts to do so have triggered vivid flashbacks of being raped:

> *After I was raped, I never had sex again with my wife or any other woman. The thought of those soldiers raping me is in my mind. **I cannot help it. I tried many times to take it from my mind, but it is always there.***

V. Spatial accessibility of health facilities in hotspot areas

1. Impact of insecurity on medical personnel and functionality of health facilities

45. HRD's investigations have found that between 2014 and 2019, health care facilities (operated by the Government and non-governmental organizations (NGOs)) and health care workers have also been subjected to acts of violence and, in some circumstances, were directly targeted as part of a strategy of forced displacement during major military offensives and counter-offensives in Unity, Central Equatoria, and Western Equatoria.[37] In Leer, for instance, the county hospital as well as NGO-run structures have been destroyed and occupied several times since the outbreak of the conflict in 2013.[38]

46. In some cases, health workers were forced to flee areas under attack along with local populations. Those who remained in order to provide a limited, life-saving presence faced serious risks, as they were deliberately attacked along with civilians. Although there is no specific mechanism to record

[37] *See, e.g.*, UNMISS & OHCHR, *supra* note 18.
[38] UNMISS & OHCHR, *Indiscriminate Attacks against Civilians in Southern Unity, April-May 2018* (10 July 2018), *available at:* https://www.ohchr.org/Documents/Countries/SS/UNMISSReportApril_May2018.pdf

acts of violence against medical personnel and facilities[39] in South Sudan, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) reports that between December 2013 and January 2018, at least 115 aid workers, including medical personnel, were killed in the conflict.[40] Deliberate attacks on health workers and facilities inherently dispossesses civilians of a crucial coping mechanism in an environment where years of conflict have increased vulnerabilities. Lack of humanitarian access has also hindered the delivery of life-saving assistance and medical supplies to people in areas where health facilities are minimal or non-functional. In the case of survivors of sexual violence, many were unable to access health care for weeks or months due to ongoing conflict, displacement, and lack of access to health care facilities and humanitarian services.

> Eve, a 42-year-old survivor from southern Unity, recalled how she was left to suffer for months without access to health care after being raped in 2018, due to the destruction and occupation of health facilities:
>
> *After the rape, I was bleeding for five days.* ***The health facilities had been destroyed,*** *so I stayed in the tukul [home] with my husband and baby, until it was safe to get out and look for help. . . There was nowhere to go at that time; we could not run to Leer.* ***I finally received medical care at [a PHCU] three months after the rape occurred****.*

2. Distribution of public health facilities

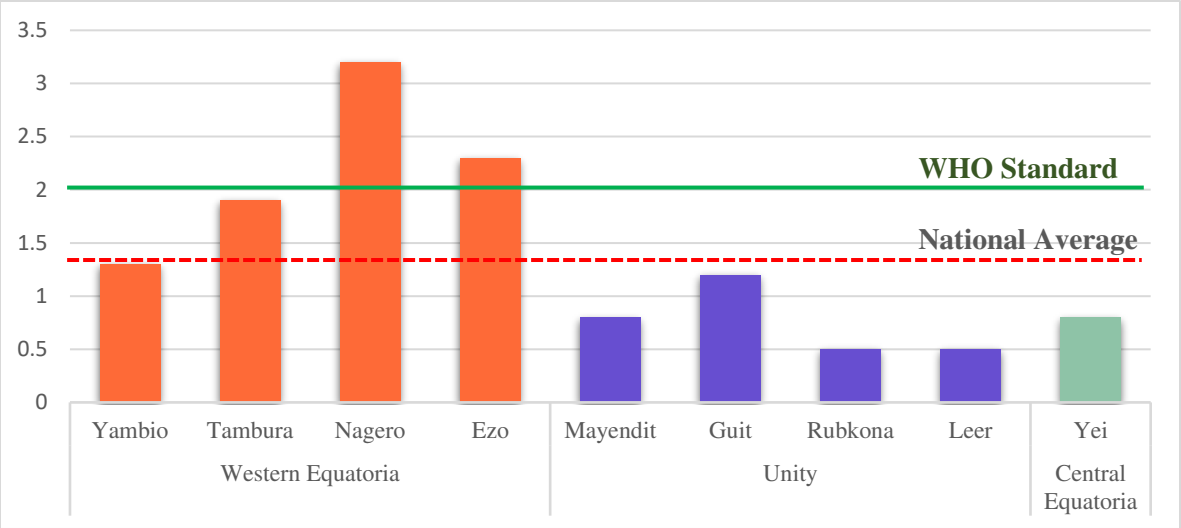
47. Through its investigations, HRD determined that, as of January 2020, 132 public health facilities were functional in the nine counties most affected by CRSV. The vast majority (97 per cent) were PHCUs (96) and PHCCs (32), which provide limited medical care for survivors of sexual violence. These facilities also included two county and two state hospitals. A major county hospital in Leer (covering southern Unity) remained non-functional at the time of the publication of this report.

48. On average, in the counties most affected by CRSV, there is only one health facility per 10,000 persons, which represents half of the WHO standard (at a minimum of two facilities per 10,000 persons), and falls below the national average of 1.43 facilities per 10,000 persons. However, there is a gap between the ratio in Western Equatoria on the one hand and in Unity and Central Equatoria on the other. The ratio of health facilities per person is much higher in Western Equatoria than in the two other states, reportedly due in part to a greater concentration of international funding and personnel, with some counties (such as Ezo and Nagero) meeting the WHO threshold. In Akobo, an area controlled by the SPLA-IO/RM, the number of functional public health facilities is even lower than in Unity, due to a lack of Government support, leading to even greater reliance on international/NGO service providers.

[39] United Nations Security Council resolution 2286 (2016) "*requests* the Secretary-General to include in his country-specific situation reports, and other relevant reports which address the protection of civilians, the issue of the protection of the wounded and sick, medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities, including recording specific acts of violence against them, remedial actions taken by parties to the armed conflict and other relevant actors, including humanitarian agencies, to prevent similar incidents, and actions taken to identify and hold accountable those who commit such acts…"

[40] Disaggregated data not available. OCHA, *South Sudan Situation Report, 30 October 2019* (31 Oct. 2019) *available at:* https://reports.unocha.org/en/country/south-sudan/

Table 2: Ratio of functional health facilities to the population, by county (January 2020)[41]



49. In all of these areas, NGOs and/or faith-based organizations have attempted to compensate for the low number of functional health facilities. Some have taken over the functioning of public health facilities while others have established their own facilities. For example, HRD found that in Leer, NGOs are the main health service providers and run their own facilities, with UNMISS Force medical personnel responding on an ad hoc/emergency basis. In Western Equatoria, while the Government operates a county hospital in Yambio, NGOs and faith-based organizations fill many of the gaps within the national health care system (providing staff to the county hospital) as well as through clinics. A single faith-based organization operates four such clinics in Western Equatoria, as well as within Yambio hospital, representing a substantial contribution to the provision of health care in the region. Similarly, NGOs operate at least four facilities in southern areas of Central Equatoria and provide support to Yei hospital, while a faith-based organization runs a separate hospital in Yei town.

50. In SPLA-IO/RM-controlled Akobo (Jonglei), where the county hospital is funded entirely by international donors, the role of NGOs in the public health system is even more pronounced. Operations at Akobo hospital are managed jointly by an international organization and county authorities. The hospital is staffed by international physicians, due to a lack of availability of national doctors, while the majority of nurses are South Sudanese nationals, working under the supervision of two international nurses.

3. Distance to reach health facilities increases risk

51. Research established that in six of the nine counties most affected by CRSV, at least 75 per cent of the population was estimated to be living more than 5 km (equivalent to a one-hour walking distance)[42] from the nearest functional public health facility. An exception to this trend was documented in three counties (Rubkona, Yambio and Yei) where major towns with a county or state hospital are located.[43]

[41] Information provided by health sector partners.
[42] This is a common unit of reference used when determining access to health care. *See, e.g.,* UNICEF, State of the World's Children, *supra* note 20.
[43] Macharia et al., *supra* note 16.

Table 3: Percentage of the population living more than 5 km from the nearest health facility[44]

County	Percentage living more than 5 km from health facility
Unity	
Guit	>75
Leer	>75
Mayendit	>75
Rubkona	70-75
County	**Percentage living more than 5 km from health facility**
Western Equatoria	
Ezo	>75
Nagero	>75
Tambura	>75
Yambio	70-75
Central Equatoria	
Yei	60-70

52. Most of these counties therefore reflect the national average (72 per cent or more living more than 5 km from the nearest health facility) as well as a pattern in SPLA-IO/RM-controlled areas such as Akobo, where more than 75 per cent of the population was also estimated to be living more than 5 km from the nearest health facility.

53. The distance separating victims of sexual violence from health facilities is a significant barrier to accessing adequate health care and exposes survivors to the risk of additional harm during their journey, as areas that are the most affected by sexual violence are also amongst the most volatile in South Sudan. Survivors' accounts indicate that these risks while travelling take multiple forms, including checkpoints and roadblocks, patrols, spontaneous movements of armed elements, and predatory attacks by single or multiple perpetrators.

> Nyamai, a 19-year-old woman who was raped by members of the SPLA-IO/RM in Western Equatoria in 2018, described the risks she would have to take in order to access treatment:
>
> *I was told to come back to the hospital for more treatments, but I never did because [among other reasons]* ***the hospital is too far from my village and I did not want to be raped again on the way to the hospital.***

54. The restriction of movement also constrained access to medical assistance and other services greatly needed by the civilian population. Civilians were frequently stopped and sent back to their villages in parts of Central Equatoria, for instance, while attempting to travel to larger towns (such as Yei) under the control of Government forces, where free medical screening and health services are provided by humanitarian organizations.

> James, a civilian from Lasu *payam* (Yei county) recalled the ominous warning of a National Salvation Front (NAS) commander to civilians who wished to seek health care in Yei in early 2019:

[44] *Ibid.*

> *[The NAS commander] said that people must rely on traditional medicine and not seek medical assistance in Lasu centre, where the "enemies" are, meaning the Government.* ***The commander said, "if you go to town and get killed, do not come here and ask me."*** *One man had tuberculosis… in February 2019, he was travelling to Lasu center to get his medication, but was stopped by NAS, who ordered him to go back to the village and use traditional medicine, instead of going to Lasu. He later died from his illness.*

55. Another victim of violence in Unity underscored the stark difference between access to medical care for those living in the protection of civilians sites and/or in urban areas, as opposed to rural areas. HRD found that this issue was particularly significant in Unity as compared with some of the other regions of South Sudan. Esther, a 70-year-old woman who was beaten during an attack in Unity, emphasized some of the challenges faced by those seeking health care in rural areas:

> ***In the villages, access to health is even more challenging because of the distance one must walk to access health facilities. Sometimes, they have nothing to give to the patient.*** *In fact, they lack everything, even pills for malaria. Some health centres have also been vandalized during the conflict. I don't know the locations, but people always talk about it."*

4. Outreach and mobile clinic programmes

56. In order to overcome the challenges of accessibility inherent to a facility-based health care system, some NGOs have developed ad hoc mobile clinic programmes to reach out to local communities. Indeed, some stakeholders see these programmes as a key tool to accessing at-risk populations for basic care, particularly in a volatile security context. Between 2018 and 2019, mobile clinics were operational in at least 14 locations[45] in the counties most affected by CRSV.

57. However, according to the investigation conducted by HRD, these clinics provided very basic care for conditions such as wounds, infections and common illnesses such as malaria, and services were generally provided in situations in which confidentiality could not be preserved. For instance, these clinics might be operated in open areas (such as under a tree), where patients could easily be observed coming or going, or their statement overheard. Due to this lack of confidentiality, most medical NGOs interviewed by HRD during this investigation indicated that none of their mobile clinics had treated any sexual violence survivors. A mobile clinic programme that was previously functional in the Akobo area to address gaps in service provision in SPLA-IO/RM-controlled territory was suspended in August 2018, and had not resumed functioning as of January 2020. In Western Equatoria, another NGO suspended its mobile clinic programme in early 2019, reportedly for security reasons, replacing it with a decentralized model of care (DMC) that provides home visits in 12 different locations, which may allow for greater confidentiality in the treatment of CRSV survivors.

58. National NGOs have played a critical role in reaching out to survivors of sexual violence. Owing to their knowledge of local and social dynamics, they are often able to link survivors living in remote areas and health care providers operating from main towns or villages. For example, in Leer, where the county hospital is not functional, national NGOs are quite often the first point of contact for survivors, and in some cases provide transportation to connect those living in more isolated areas to health service providers in town, reducing survivors' exposure to further risks of sexual violence by armed elements while walking on main roads through the region.

[45] Nine of these are in southern Unity, and five in southern Central Equatoria.

VI. Readiness of medical care for rape survivors

1. Clinical management of rape

59. The clinical management of rape (CMR) focuses on five main interventions: the treatment of wounds and injuries; the prevention of HIV infection; the treatment of other STIs; the prevention of pregnancy; and the provision of psychological first aid.[46]

60. Before any intervention, taking the patient's case history is an indispensable part of the CMR process. It helps health care providers to build trust with survivors, and to understand a survivor's social background and the context in which the rape occurred. The case history is part of standard diagnostic care, which may include a physical and genital examination, with the survivor's consent. Many of the health care service providers interviewed by HRD reported using the WHO guidelines, which are based on a survivor-centred approach, requiring that informed consent is obtained at all stages of the process.

1.1. Treatment of injuries

61. PHCCs and county hospitals with on-site doctors and nurses are generally capable of providing treatment for less severe injuries (such as cuts, abrasions, and fractures). For more complex cases, survivors may need the care of physicians with specialized training, particularly gynaecologists, who may only be found in state hospitals. In some state hospitals covered by HRD investigations, health workers frequently encountered difficulties in sterilizing instruments and maintaining a cold chain to store medication and vaccines, due to frequent power cuts and lack of funding. State hospitals in the areas covered by the investigations have the capacity to conduct basic surgery (such as incision and drainage of abscesses, suturing of wounds, and closed treatment of fractures)[47] but in life-threatening situations, they may refer patients to Juba Teaching Hospital, which has the capacity to conduct a broader range of surgical procedures. Cases that require specialized training or equipment, including those involving surgery to repair fistula, may be referred to facilities in countries of the sub-region, such as Ethiopia and Sudan. Ad hoc treatments may occasionally be available within the country.[48]

62. In areas outside of Government control, international NGOs supplement state and county hospitals. In Akobo, for instance, which is controlled by the SPLA-IO/RM, an international organization provides similar care to that delivered by state or teaching hospitals within Government-controlled territory, with physicians, nurses and midwives on staff, a functional operating theatre, and an HIV treatment programme.

1.2. Human immunodeficiency virus and other sexually transmitted infections

63. HRD found that post-rape treatment kits, which contain medication for post-exposure prophylaxis (PEP) of HIV infection, STIs and emergency contraception, as well as medication to address the side-effects of these treatments (such as nausea and vomiting), were available at the three major hospitals and at select PHCCs in the areas covered by the investigation. They were also available at all NGO-run facilities. This appears to be the case in areas controlled by the SPLA-IO/RM as well: in Akobo,

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[46] WHO & United Nations High Commission for Refugees (UNHCR), *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons* (2004), *available at:* https://www.unfpa.org/publications/clinical-management-rape-survivors [hereinafter "WHO guidelines"].

[47] As defined by SARA, *supra* note 11.

[48] For example, in the case of fistula, United Nations agencies support the periodic visits of specialists from outside of South Sudan to conduct fistula repair surgery and to train local health workers in the management of fistula cases.

for instance, HRD found that post-rape treatment kits were available at the county hospital. These kits are supplied entirely by international organizations.

64. Treatment for the prevention of HIV infection must be administered within 72 hours of the rape to be effective, while for other STIs, treatment may be administered beyond this window. Emergency contraception may also be effective in preventing pregnancy for up to five days. In general, health workers informed HRD that they had adequate knowledge about PEP treatment as a result of trainings provided by various organizations. HRD is not aware of any in-depth survey assessing the use of post-rape treatment kits by health workers in South Sudan.

65. Regardless of the level of training or skills developed amongst health professionals, HRD found that a limited number of survivors had received PEP treatment. Very few were able to access health facilities that had these kits on hand within 72 hours after being raped,[49] with the exception of victims living in the main towns and protection of civilians sites. Most of the health workers and survivors interviewed, including those in SPLA-IO/RM-held areas, told HRD that survivors often seek treatment at the hospital or health facilities only after developing complications (primarily infections or unwanted pregnancy).

> Awut, 30 years old, recounted that she did not disclose that she had been gang-raped in 2018 until she started to experience a flu-like illness:
>
> ***Because I was ashamed, I did not tell anything to anyone until I started to have sickness.*** *I went to the hospital and had myself examined for flu and not for rape. But after several tests, I was told that I was not pregnant but was positive for syphilis. I burst into tears and forced myself to tell them that I was raped. It was so intimidating and embarrassing for me to share it. The most difficult thing was to tell my husband, because I had sex with him after I was raped.*

66. Apart from the state hospitals, in general PHCUs, PHCCs and county hospitals lack access to the appropriate equipment or laboratory facilities and cannot provide treatment for more complex conditions, such as hepatitis or HIV.

67. While it is critical for survivors to access treatment within the 72-hour window, according to the WHO guidelines[50], it is equally important for them to complete the full course of medication prescribed for the prevention of HIV infection, as well as for the treatment of any infection that may have been contracted as a result of the rape. This treatment should generally be completed within three months, and include follow-up visits to health care service providers to monitor progress. Follow-up treatment can place significant burdens on survivors, requiring multiple trips to health facilities, and exposes them to the risk of being "outed" to members of the community.

> Susan, a 47-year-old survivor in Unity, described the burden of follow-up treatment for syphilis resulting from rape:
>
> ***I had to go to the clinic more than six times because I had syphilis****. This was a traumatic experience for me because I was very healthy before the rape.* ***Of course, nobody knew what I was suffering from. I would just walk to the clinic and sneak in.*** *I stayed in town during the whole treatment.*

[49] Multiple health services providers indicated to HRD that HIV PEP treatment is generally not provided to survivors after the 72-hour window has elapsed, when the effectiveness of this treatment diminishes significantly.
[50] *See infra* para. 37.

68. The effectiveness of treatment therefore relies on how successfully service providers are able to provide survivors with the full course of treatment and medication. Service providers indicated that in many cases, survivors do not return after their initial visit to complete treatment. Moreover, the side effects of the multiple medications are often severe and may interfere with the survivor's ability to function on a day-to-day basis. Survivors may also feel unable to take their medication regularly for a three-month period or to make multiple visits to health care service providers, due to fear of stigmatization by partners, other family members and communities. In other cases, it is impossible for service providers to trace patients for follow-up care, due to population movement/displacement in the context of conflict and insecurity in South Sudan.

1.3. Access to reproductive health: unwanted pregnancy and unsafe abortion

69. Unwanted pregnancy resulting from rape is one of the main reasons leading survivors to seek medical care. Women and girls who become pregnant as a result of rape often face the risk of being ostracized or rejected by their families and communities.

> Elizabeth, a health worker, recounted the case of Serena, a 16-year-old girl who came to a health facility pleading with midwives to "remove the baby from her belly." She had become pregnant after being raped by multiple armed elements in February 2019 while searching for firewood:
>
> *Serena told her mother what happened to her, but she was told not to report it to anyone or she would not find a husband in the community. A few months later, she begged her mother to take her to the hospital because of abdominal pain. She refused. Instead, her mother gave her some traditional medicine. As the pain grew worse, Serena ran away from her home and came to the hospital. She was almost four or five months pregnant. She begged us to remove her baby. We informed her mother, but it was too late for an abortion.*

70. Survivors and medical practitioners however indicated that carrying a forced pregnancy to term is often not a feasible option, in particular if the survivor is a married woman or the pregnancy resulted from a rape perpetrated by armed elements reportedly siding with "the enemy."[51]

> Joyce, a 22-year-old survivor in Unity, recalled that discovering that she was pregnant approximately two months after being raped was "*the saddest day of [her] life, because [she] knew what was next*":
>
> *Many thoughts came to my mind, and* ***I said to myself, 'how can I bring this kind of child to this life?*** *A child with no father. How can I look at this child one day and tell him that he is the result of rape by four unknown gunmen?'* ***I said to myself, 'you are not going to keep this thing and bring more shame***.'

71. This type of case is not uncommon in South Sudan, as rape has been used as a weapon of war to deliberately impregnate women and girls from opposing communities or factions. During an investigation carried out in Central Equatoria in late 2018 and early 2019, for example, HRD documented accounts indicating that perpetrators attempted to forcibly impregnate women and girls from communities suspected of sympathizing with opposition forces.[52] In this context, abortion may

[51] In Central Equatoria, HRD documented accounts indicating that perpetrators deliberately raped women to impregnate them with their own child and transform the demographic landscape of South Sudan by producing children with women and girls from other communities. *See* UNMISS, Central Equatoria report, *supra* note 18.
[52] UNMISS, *Conflict-related violations and abuses in Central Equatoria, September 2018-April 2019* (3 July 2019).

be viewed by the survivor's family or community as a means of avoiding the birth of the child of a perceived enemy or as a way to ensure the payment of a high bride price (which is conditioned on virginity).

72. However, abortion is criminalized in South Sudan, except in cases where it is necessary to save the life of the pregnant woman, though this medical necessity must be proven in court.[53] HRD found that abortion is consequently often practiced in unsafe conditions and without medical supervision. The most common form of unsafe abortion appears to be an ingestible preparation made from locally available herbs and plants, which has a toxic effect on multiple bodily systems and causes the survivor to abort by making her extremely physically ill overall. Unsafe abortion may, in turn, lead to other health complications, such as excessive blood loss and severe infection, which can be fatal.[54]

1.4. Availability of medication

73. According to the Ministry of Health, since 2012, 72 essential drugs have been regularly procured by international donors (such as the Health Pooled Fund[55] and the World Bank) and distributed throughout the country three times per year (once every four months) by road and, where roads are impassible, by air. HRD found that if these supplies are exhausted before the end of a four-month delivery cycle, Government health facilities must seek additional supplies on an ad hoc basis from NGOs in the area, which may or may not be available.

> Lucy, a 21-year-old survivor in Western Equatoria, described the situation faced by some survivors when they attempt to obtain treatment, including medication, in more rural areas. She was given an antibiotic (amoxicillin)[56] but no treatment for the prevention of HIV infection, pregnancy, or pain:
>
> *I told my grandmother about what happened because I felt so sick and was in too much pain right after I was raped. My grandmother told the chief of our village and they both took me right away to the [PHCC] where I was given amoxicillin. That was the only medication I received from the facility. . . I was not given any tests. . . nobody was telling me I needed to go for a follow-up examination.*

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[53] Section 216 of the South Sudan Penal Code Act of 2008. Under international human rights law, denial of access to abortion may constitute a form of gender-based violence, and torture and ill-treatment in certain circumstances, including in cases of sexual violence. *See, e.g*., Committee on the Elimination of Discrimination against Women, General Comment 35, para 19; Human Rights Committee, Mellet v. Ireland, para 9, CCPR/C/116/D/2324/2013; Whelan v. Ireland, para 9 CCPR/C/119/D/2425/2014; Human Rights Committee, K.L v. Peru, para 6.6, CCPR/C/85/D/1153/2003 Human Rights Committee also notes that "States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable." Human Rights Committee, General Comment 36 on Article 6 of the International Covenant on Civil and Political Rights (ICCPR), on the right to life, para 8.

[54] According to WHO, "Each year between 4.7% - 13.2% of maternal deaths can be attributed to unsafe abortions," https://apps.who.int/iris/bitstream/handle/10665/329887/WHO-RHR-19.21-eng.pdf?ua=1.

[55] Comprised of funding from the UK Department for International Development (DFiD) (the lead donor), Canada, the European Union, Sweden and the United States Agency for International Development (USAID). *See infra* Section VIII for additional information on HPF.

[56] Amoxicillin is frequently prescribed to treat chlamydia, gonorrhea, and urinary tract infections. However, it may not be sufficient on its own to treat these and other bacterial infections, due in part to increased resistance to antibiotics, and is ineffective in the prevention and treatment of viral infections such as HIV and Hepatitis C. *See* WHO, "WHO launches new treatment guidelines for chlamydia, gonorrhea and syphilis", https://www.who.int/reproductivehealth/topics/rtis/stis-new-treatment-guidelines/en/.

74. In several instances, survivors told human rights officers that public health facilities do not always have adequate supplies of medication. Therefore, the survivor may be provided with a prescription to purchase medication at the local market.

> Anna, a 40-year-old survivor, expressed her frustration with the lack of available medication:
>
> *I don't want to go to the hospital although I don't feel good… During my last visit I was told there was no medicine. I was given a prescription to buy the medicine at the local market. I had no money to buy those drugs. If I go back to the hospital, I will be told the same thing, because this happened to other people I know.* ***I don't want to hear the same thing again, so I don't bother going to the hospital anymore.***

75. In a country where an estimated 82 per cent of the population is living under the international poverty line of USD 1.90 (PPP) per capita per day,[57] even a relatively small fee for medical services or medicine can put them out of reach for the average survivor. In this context, traditional medicine may be seen as a viable alternative, as described by Veronica, a 40-year-old survivor in Unity:

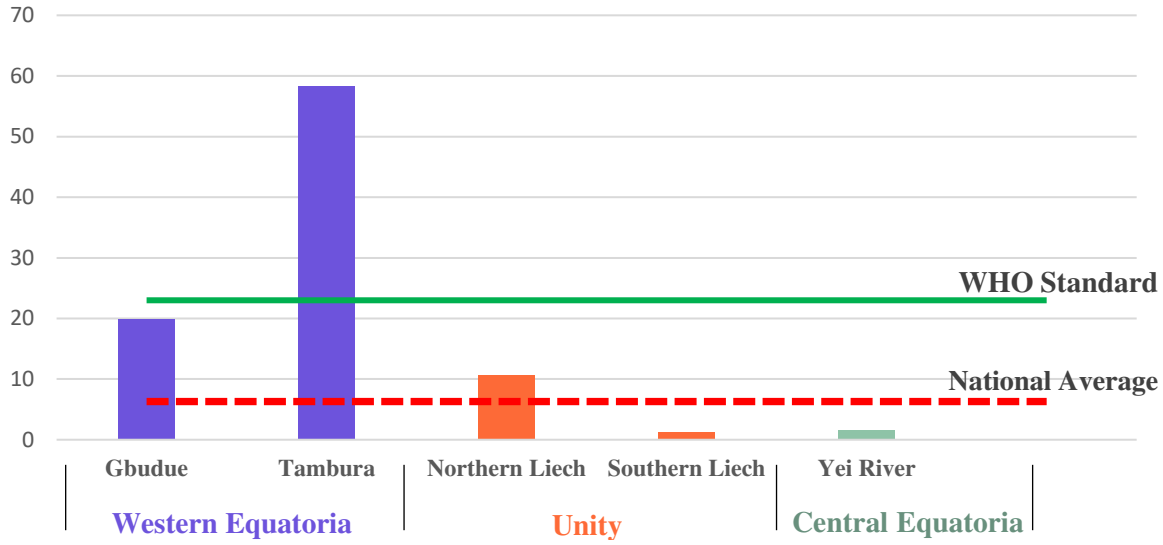
> *After taking all the pills with no real improvement,* ***I resorted to traditional medicine from my village****. I must make several trips to the village to get herbs and roots. Of course, these trips are affecting my business, but* ***herbs are cheaper than drugs****. As of now, I cannot do farming activities or collect firewood because of pain, including severe headaches.*

2. Health worker ratio and skills

76. According to SARA, in most of the areas covered by the HRD investigation, the ratio of core health workers to the population fell short of WHO minimum standards for the provision of basic health care services (at 23 core health workers[58] per 10,000 members of the population). In order to close this gap, at least 1,185 core health workers need to be deployed in the former Northern and Southern Liech (Unity State), Yei River (Central Equatoria) and Gbudue states (Western Equatoria).[59]

[57] Figures as of 2016. World Bank Group*, South Sudan Poverty Assessment, 2009-2017*, at 21.
[58] "Core health workers" are defined by SARA as physicians, nurses and midwives (health service providers) and does not include personnel such as case managers, counselors, laboratory physicians, or administrative staff. It should be noted that Akobo was not included in SARA.
[59] Calculation based on total population as derived from SARA.

Table 4: Ratio of core health workers to the population, by state (as of 2019) (SARA)[60]



77. The low ratio of core health workers in the majority of the areas most affected by CRSV means that many survivors face challenges in accessing treatment by a doctor, nurse or midwife when reaching health facilities, potentially affecting the quality of care they receive. In addition, HRD found that in some cases, due to an overall lack of staffing, core health workers may also be required to perform management tasks, oversee stocks and maintain equipment, placing further strains upon their time.

78. HRD also learned that very few core heath workers received specific training on CMR while attending medical or nursing and midwifery schools. As a result, they rely essentially on training provided on site by international partners or NGOs. During the investigation, HRD was informed that most health workers were sensitized to basic principles of CMR, including the use of post-rape treatment kits. However, these trainings are often organized on an ad hoc basis, based on perceived need, and depend on the availability of funding and priorities established by training organizers. CMR training, for example, generally lasts for five days, and is followed up by a three-day refresher training. However, at the time of reporting, there had been no evaluation of the effectiveness of training, and there did not appear to be on-site mentorship by professionals to ensure that training is applied.

79. On a positive note, Bentiu, Yambio and Yei hospitals operate specialized gender-based violence units with both medical and psychosocial components, through the support of the international community. These units are staffed primarily by midwives and nurses who have received CMR training, as well as a non-medical gender-based violence coordinator. The three hospitals have at least one physician affiliated with the unit. However, very few specialists are available in these hospitals to handle complex sexual violence cases, such as those requiring major surgery. In September 2019, a one-stop care centre opened in Yambio, offering a wide range of services in addition to what was already available, including counselling and legal support. Additionally, while the Akobo hospital does not

[60] The information is not available at the county level. Following the reversion to 10 states, the states cited in the graph comprise the current counties: Gbudue (Anzara, Ezo and Yambio), Tambura (Nagero and Tambura), Northern Liech (Guit, Koch, Mayom, and Rubkona), Southern Liech (Leer, Mayendit and Panyijar), Yei River (Kajo-Keji, Lainya, Morobo and Yei). In addition, the large number of health workers in the former Tambura state (Nagero and Tambura counties) is due primarily to a concentration of health workers and resources in counties that are not amongst those most affected by CRSV.

have a dedicated gender-based violence unit, it has the capacity to provide appropriate medical services to survivors, and has worked with partner organizations to establish a referral pathway for psychosocial support.

2.1 Daily challenges faced by health workers

80. Throughout the investigation, HRD consistently interacted with public health care workers who have managed to provide essential services despite the tremendous challenges they face in their work, including very low and frequently delayed salaries, a lack of equipment and supplies, overwhelming demand and in some areas, ongoing insecurity. These challenges are amplified outside of Juba, where conditions may be even harsher. When HRD asked John, a 40-year-old health care worker, why he chose to remain at a facility at one rural location, despite the major challenges he faced, his response spoke to the dedication that HRD observed amongst many of the medical professionals interviewed for this report:

> ***It is a challenge every day, and many people do not want to stay here.*** *Fortunately, with the incentive, I can support my family, which is what allows me to stay here. It is difficult work. You have seen the conditions we are working in.* ***But if we want to build our country, we all have to face these challenges and work together to make our country better****. I think that by doing this, I am also showing my children that it is important to help other people and to try to build a better future for South Sudan.*

81. The provision of incentives (stipends), funded by the Health Pooled Fund (HPF), has filled a critical gap in the retention of health care workers. However, the harmonization of incentives in 2017 reportedly resulted in a reduction in some individual incentive payments, leading to an increase in absenteeism and staff quitting to seek other employment, according to several respondents. Due to the shortfall in staff numbers, many HPF implementing partners have acted as health staff.

82. In areas under Government control, the salary of Government workers is tied to the South Sudanese pound (SSP), which has substantially decreased in value following significant inflation.As of January 2020, many health care workers reported that their Government salaries had decreased in value to anywhere between 10 and 40 USD per month. Health workers interviewed by HRD acknowledged that they therefore relied on the HPF incentive to sustain themselves and their families. In Akobo, for example, health workers do not receive a Government salary at all, and are fully reliant on incentives from international donors. The salaries offered by NGOs, as well as opportunities available in neighbouring countries (such as Kenya and Uganda), are often more attractive and draw some health care workers away from the South Sudanese public health system—leading to a low retention rate and regular rotation of health care workers within the national system.

2.2 Mental health and psychosocial care

83. As illustrated by the accounts in this report, women and girls are often compelled to suffer in silence, due to the stigma surrounding both mental health issues and sexual violence, as well as the practical reality that they often do not have time to take care of their own needs, prioritizing family and domestic obligations. There is also a lack of awareness of mental health issues and of the importance of receiving psychiatric or psychosocial support to treat trauma-related conditions.

84. The South Sudanese population has been living with high rates of trauma and related mental health issues for decades in the context of conflict, without any meaningful access to mental health care services.

As Rachel, a health care worker, observed, access to mental health care has been perceived as low-priority in light of the country's other challenges:

People in South Sudan do not have time to think of whether they have mental problems or not; they have to provide for their families. Daily survival and having something to eat are the main concerns of most South Sudanese citizens. In people's minds, mental health can wait.

85. The duration of mental health treatments for survivors of sexual violence may also vary according to the severity of each patient's response. Psychiatrists interviewed by HRD observed that at least four to six months of treatment, including medication and counselling, are advisable. In addition, psychiatric medication is costly and in extremely limited supply, and most of the population cannot access it.

86. Psychosocial support is a related but distinct form of care that aims to address the combined social and psychological impacts on a survivor's well-being, particularly in emergency settings. It may be provided by actors other than health workers, but is not meant to replace treatment by professional psychiatrists or psychologists where such treatment is urgently needed.[61] It may include psychological first aid[62], case management, and programming to build survivors' capacities to handle the social impacts following a rape. In South Sudan, the majority of psychosocial care providers working for Government-run facilities are in state hospitals and have received a limited amount of formal or on-the-job training.

87. Trained health care workers, such as nurses and midwives, as well as social workers, in theory, may be able to provide psychological first aid to survivors. Faced with the harsh reality of assisting survivors and their families, some health workers try to manage the situation with their basic knowledge. Therefore, the quality of these interventions may vary significantly and risk further traumatizing the survivor.

VII. Social barriers

88. Survivors of sexual violence throughout the world face social barriers to reporting their experience and seeking appropriate care, due to feelings of shame and fear of stigmatization. In South Sudan, these barriers are intensified for women and girls by the continued practice of the bride price, which is closely linked with their virginity prior to marriage. Women and girls who are raped before marriage may thus be perceived as "spoiled" and unmarriageable, and therefore unable to obtain a high bride price. If a bride price has not been fully paid, husbands may seek to repudiate the marriage contract. Survivors who are married at the time of the rape may be rejected by their husbands or evicted from their homes.

[61] Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support, *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* 1 (2010), *available at:* https://www.unicef.org/protection/what_humanitarian_health_actors_should_know.pdf

[62] According to the IASC Reference Group for Mental Health and Psychosocial Support, psychological first aid "entails basic, non-intrusive pragmatic psychological support with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. . . It is very different from psychological debriefing, in that it does not necessarily involve a discussion of the event that caused the distress." Such psychological debriefing is "at best, ineffective" and is strongly discouraged by the IASC guidelines. *Ibid.*, at 11.

89. Sixteen-year-old Mercy, who was gang-raped by SPLA-IO/RM elements in Western Equatoria in 2018, spoke with HRD about the stigmatization she later experienced within her family and community:

> *When I was out of the hospital and went back to my village, my life became more difficult. My neighbours were talking about me, and boys were laughing at me.* ***The worst part was when my father told me 'You are already spoiled by those rebels and no longer have value to me, so do not expect me to lend anything for you. You must take care of yourself now. You should be grateful I am still letting you stay in my house.'*** *For me to continue my studies, I sell cassava leaves at the market and in town and try to save as much as I can to pay my school fees.*

> Martha, a 30-year-old mother of two who was gang-raped by SPLA-IO/RM elements in Western Equatoria in 2018, described the emotional fallout she experienced after revealing to her husband that she had been raped:

> *When I told my husband that I was raped, he was so upset and angry that he wanted to leave right then.* ***He still talks about how I was raped by the rebels and yells at me, telling me it was my fault. . . it feels like I am bleeding inside because of the pain from his insults.*** *Recently, I was tempted to run away with my children and never come back, but I don't want to risk their lives and future because of my problems with my husband.*

90. Similarly, while male survivors everywhere face significant social barriers to reporting, deeply-entrenched social taboos surrounding homosexuality, as well as a highly militarized masculinity, compound these challenges in South Sudan. Twenty-three-year-old David, who was gang-raped by seven SPLA soldiers in Central Equatoria in 2016, described the ongoing impacts of the attack on his life three years later, and the impossibility of telling his story to even his closest family members:

> *I did not expect such a thing to happen to me, but* ***I cannot even tell anyone about it – not even my family. No one will treat me like a man again if they know****. . . The incident humiliated me so much.* ***I was treated like less than even an animal.*** *Every time I think about what happened, I feel very angry, like I want to kill all of the men who did this to me.*

91. In this context, the revelation that an individual has been raped can have devastating personal consequences, leading many survivors to take all necessary measures to prevent disclosure, including by concealing their experience from close family members, or refraining from follow-up treatment in cases where the latter may increase the likelihood of discovery.

VIII. Policy and budgetary framework

1. Policy framework

92. In 2016, with the support of WHO and the European Union, the Government of South Sudan reviewed and amended its National Health Policy (2016-2026).[63] One of the main objectives of this policy was to strengthen delivery of the Basic Package of Health and Nutrition Services (BPHNS) on an equitable basis throughout the country, primarily through support for primary health care centres (PHCCs) and units (PHCUs) as well as universal health coverage.

93. To this end, the Boma Health Initiative (BHI) was established in 2017. The programme is designed to standardize and improve access to and delivery of health services at the community level, including basic sexual and reproductive health services, through the training and deployment of community health workers trained in health promotion, disease prevention and selected curative interventions. According to the Ministry of Health, this initiative is meant to enhance the community health services currently provided by NGOs, which has reportedly led to duplication, fragmented training and supervision, as well as resource wastage, due to a lack of coordination between Government and NGO partners.[64]

94. If effectively implemented, a community-based care approach such as BHI represents a complementary strategy to overcome challenges that inherently arise from facility-based health care delivery in the context of armed conflict and insecurity. However, while BHI may offer solutions in settings where facility-based programmes are not accessible to women and girls who may be most in need of these services, it also comes with its own challenges in terms of medical and ethical protocols, such as the protection of patient confidentiality and security. To date, the potential benefits of BHI remain untested, as its roll-out began in June 2019.

95. The National Health Policy also commits the Government to developing guidelines for the examination and treatment of victims of gender-based violence and to support advocacy on behalf of survivors. As of January 2020, there were no official CMR guidelines, which would standardize the package of medical and mental health care services for survivors of sexual violence, although draft guidelines were reportedly under review by the Ministry of Health.

96. As a result, no minimum standards for the treatment of victims of sexual violence were in place as of January 2020, leading to significant differences in the types and quality of services provided throughout the country. Several Government representatives acknowledged to HRD that they did not exercise control over protocols applied by NGOs or private clinics, as long as procedures put in place did not violate national law.

2. Budgetary framework

97. The Government of South Sudan allocates a meagre portion of its budget to the public health sector, leading to a health care system that is dependent on international donors for more than 90 per cent of its funding. In this context, international actors have largely shouldered the burden of providing health

[63] The Republic of South Sudan, *National Health Policy (2016-2026). A community anchored health system for a sustainable health sector*, May 2016. http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/south_sudan/south_sudan_national_health_policy_2016_to_2025_2.pdf

[64] Ministry of Health, UNICEF and Management Sciences for Health, *The Boma Health Initiative. Costing and Investment Case Analysis*, April 2019. https://www.unicef.org/southsudan/media/2031/file/South-Sudan-2019-BHI-Costing-Investment-Case-Analysis.pdf

care services to meet the immediate needs of the most vulnerable communities and to support the development of a more sustainable health system. This, in turn, has led to a perception that the Government is exonerated from its obligation to provide basic health care services.[65]

2.1 Government budgetary allocation for the health sector

98. The public health sector has consistently been a low priority in terms of Government budgetary allocation in South Sudan. Between the 2018-2019 and 2019-2020 fiscal years, allocations for the public health sector decreased from 2[66] to 1.2 per cent, in line with past trends.[67] By comparison, in 2018-2019, the security, public administration and accountability sectors absorbed 73 per cent of the approved budget, with a primary focus on salaries (about 70 per cent of the total budget), to compensate for arrears in past salary payments.[68]

99. While the percentage of budgetary allocations to the health sector decreased in the 2019-2020 fiscal year, due to an increase in national revenue in the 2019-2020 national budget forecast[69], actual financial allocation increased as compared with 2018-2019 by approximately 455 million SSP (USD 2.8 million).[70] Overall, the official planned budgetary allocation for 2019/20 has increased to USD 14-15 million. Nonetheless, this represents only about 8 to 9 per cent of the estimated USD 167 million of the budget required to sustain the health sector in 2019/20, according to international stakeholders and as calculated by HRD on the basis of available information[71]. Moreover, at USD 14 million, the allocation for the entire public health sector is less than what is earmarked to cover health care for South Sudanese parliamentarians (USD 20 million) during the same period—a stark indication of the Government's perceived responsibility in providing health care for the people of South Sudan.[72]

100. The Government's overall allocation on health (at 1.2 per cent) also falls far short of standards established by the 2001 Abuja Declaration.[73] The United Nations Children's Fund (UNICEF) estimates, for example, that in order to meet international targets, 15 per cent of the fiscal year budget should be allocated to the public health sector.

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[65] While States Parties to the International Covenant on Economic, Social and Cultural Rights are advised, according to available resources, to facilitate access to economic, social and cultural rights in other states, the burden of providing access to these rights falls first and foremost to the Government of South Sudan. For an extended discussion of the relevant legal framework, *see infra* Annex 1: Legal framework.

[66] 1,791,641,902 out of 80 billion SSP (80,451,118,389 – see http://grss-mof.org/wp-content/uploads/2019/07/Draft-Budget-Book-2019-2020-50-Books-compressed.pdf)

[67] Since the Comprehensive Peace Agreement, the share of health in overall government expenditure decreased from 3.8 per cent in 2006 to 2 per cent in 2015. Source: World Bank. http://documents.worldbank.org/curated/en/236571543237264655/text/Concept-Project-Information-Document-Integrated-Safeguards-Data-Sheet-Protection-of-Essential-Health-Services-Project-P168926.txt

[68] UNICEF, *National Budget Brief. South Sudan 2019*, https://www.unicef.org/southsudan/media/2201/file/%20UNICEF-South-Sudan-National-Budget-Brief-2019.pdf

[69] Approved budget is 208,155,265,545 SSP or 1.292 million USD at the official exchange rate of 161 SSP @1 USD (Source: United Nations Development Programme (UNDP) Briefing note, 20/09/2019). Health budget amounts to 2,246,791,987 SSP (Source: UNDP, document shared 26 Sept. 2019).

[70] The detailed fiscal year 2019-2020 budget breakdown was not available at the time of writing. As such, calculation is based on the fiscal year 2019-2020 budget estimates.

[71] This amount was calculated on the basis of major sources of funding provided by confidential sources.

[72] South Sudan Ministry of Finance and Economic Planning, *supra* note 7.

[73] In April 2001, Heads of State of African Union countries met in Abuja, Nigeria, where they pledged to increase funding allocations for the health care sector, setting a target of at least 15 per cent of national budgets. *See, e.g.*, WHO, *The Abuja Declaration: Ten Years On* (2011), *available at:* https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1.

101. Several sources interviewed by HRD indicated that the majority of Government budgetary allocations for health would likely be absorbed by salaries and arrears for approximately 4,000 staff.[74] Some respondents also questioned how much of the USD 14-15 million would be effectively received by the Ministry of Health, as there have reportedly been discrepancies between budget allotments and actual spending by the Ministry during past budget exercises.[75] One international think tank observed that South Sudan's budgets are "*unreliable and generally do not reflect the realities of government spending priorities. Actual spending is a function of day to day patronage and power relations more than the official budget process.*"[76]

102. Accordingly, the nominal role played by the Government in supporting the public health sector is symptomatic of—and enabled by—its extreme dependence on international funding.

2.2 Donor funding mechanisms

103. Several multi-donor funding mechanisms support the health sector in South Sudan, including the Health Pooled Fund (HPF), the World Bank, the Global Fund and the United Nations-administered South Sudan Humanitarian Fund (SSHF). HRD found it challenging to establish the exact quantity of funds allocated to the health sector, considering that in addition to these multi-donor mechanisms, bilateral assistance and privately funded NGO interventions also contribute to funding the health care sector.

104. The HPF, comprised of the UK Department for International Development (DFiD) (the lead donor), Canada, the European Union, Sweden and the United States Agency for International Development (USAID), is the main multi-donor funding mechanism for the health sector in South Sudan. It is designed to respond to the immediate health needs of the population through contracted implementing partners, using existing facilities under the Ministry of Health and health staff in eight of the 10 states[77], including the areas covered in this report. The remaining two states of the country, Jonglei and Upper Nile, are supported through the World Bank Fund Protection of Essential Health Services Project[78], a two-year project of over USD 105 million.

105. Between October 2012 and December 2018, HPF allocated over USD 245 million in support of the health system, equating to USD 8.5 per capita for services, according to an evaluation carried out in July 2018 by an independent consulting firm.[79] For 2019-2020, an additional USD 75 million was due to be allocated to the health sector. As of 2019, HPF was supporting 801 facilities through the provision of essential drugs and incentives for health workers, as well as programmes to build the capacity of Government staff. The retention of health care workers in the public health sector is highly dependent on the payment of this incentive. For instance, during the harmonization of this incentive in 2017, some health workers, who had previously been paid more than the new threshold, experienced a reduction in the amount of their incentive payments, and consequently left their positions.

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[74] Confidential meetings held in Juba on 5 and 13 September 2019.
[75] According to UNICEF, a dearth of data prevents the calculation of the difference between the total amount of funds released by the Ministry of Finance and Planning (to spending agencies) and the total amount of funds that are actually spent by these agencies by the end of the fiscal year. *See* UNICEF, *National Budget Brief, South Sudan 2019*.
[76] Confidential source [report on file].
[77] Central Equatoria, Eastern Equatoria, Lakes, Northern Bahr el Ghazal, Unity, Warrap, Western Bahr el Ghazal, and Western Equatoria.
[78] http://documents.worldbank.org/curated/en/236571543237264655/text/Concept-Project-Information-Document-Integrated-Safeguards-Data-Sheet-Protection-of-Essential-Health-Services-Project-P168926.txt
[79]Integrity, *Evaluation of the South Sudan Health Pooled Fund. Final report*. 10 July 2018, http://iati.dfid.gov.uk/iati_documents/35675062.pdf

106. Despite these major investments, one consulting firm's evaluation of HPF noted that "*the majority of health facilities [supported by HPF] lacked adequate infrastructure to ensure a GBV survivor's privacy, safety and confidentiality. Many health facilities do not have the needed knowledge and skills to assist GBV survivors, particularly the survivors of rape. Findings revealed a lack of GBV and CMR protocols and referral pathways*."[80]

107. By contrast to HPF, the World Bank project ("Provision of Essential Health Services"), which was launched in early 2019,[81] places greater emphasis on the medical response to sexual violence than HFP. The project identifies the delivery of medical care to victims of sexual violence and the training of health professionals on treatment and counselling as key components of the programme.[82]

108. In addition to these two main funding sources, other mechanisms have been established to support the health sector or emergency health response, including the Global Fund programme to fight AIDS, tuberculosis and malaria[83] and the South Sudan Humanitarian Fund (SSHF). SSHF is a multi-donor country-based pooled fund (CBPF) administered by the United Nations and established to support activities that have been prioritized as the most urgent and strategically imperative to address critical humanitarian needs in the country. As part of its main objectives, SSHF is designed to provide life-saving responses to address the protection needs of gender-based violence survivors and to support awareness-raising projects. Between 2018 and 2019, over USD 18 million were allocated to protection needs, particularly gender-based violence-related activities and health activities by SSHF.[84]

109. SSHF has been a flexible funding platform for local early response measures, including for some international and national NGOs operating in volatile areas where incidents of sexual violence have been reported. However, the challenge of linking short-term funding, such as those earmarked under SSHF, and long-term funding has left some national partners vulnerable to shifting priorities.

110. In addition to HPF and SSHF, several United Nations agencies including UNFPA, UNICEF, WHO and the Joint United Nations Programme on HIV and AIDS (UNAIDS) support the public health sector through various programmes mainly implemented by national and international NGOs. Their major areas of intervention have centred around access to basic health and reproductive health care and HIV services. During this investigation, HRD was not been able to determine the annual budget earmarked to support the health sector by the United Nations system.

111. Overall, the variety of donor mechanisms, with differing priorities and funding duration, highlights the challenge of efficiently linking humanitarian projects providing medical responses for survivors of sexual violence to development programmes addressing structural shortcomings in the public health sector. These challenges are compounded in a context where Government authorities are characterized by weak economic governance and low budget credibility. In this regard, in early 2019, following the signing of R-ARCSS, the Work Bank noted in the concept note of its Essential Health

[80] Integrity, *Evaluation of the South Sudan Health Pooled Fund. Final report*. 10 July 2018, http://iati.dfid.gov.uk/iati_documents/35675062.pdf

[81] Taking over from the Rapid Results Health Project, which ran from 2013 to 2018, was a USD 57 million World Bank-funded initiative aimed at strengthening the capacity of health systems throughout Jonglei and Upper Nile states to provide preventive and curative health services. It ran from 2013 to 2018.

[82] http://documents.worldbank.org/curated/en/236571543237264655/text/Concept-Project-Information-Document-Integrated-Safeguards-Data-Sheet-Protection-of-Essential-Health-Services-Project-P168926.txt

[83] For the three-year period, under the current 2018-2020 programme, a grant of USD 32.68 million for HIV programming, a USD 9 million grant for tuberculosis, and a USD 45 million grant for malaria. Confidential meeting held in Juba, 24 September 2019.

[84] See South Sudan Humanitarian Fund. Annual Report 2018, https://www.unocha.org/sites/unocha/files/South%20Sudan%20HF%20Annual%20Report%202018_1.pdf

Services Project that "funding for development assistance continues to decline in favour of programmes more linked to emergency and humanitarian assistance."[85]

112. As long as the Government of South Sudan does not take drastic measures to prioritize health care services and raise adequate revenue earmarked for the public health sector, it will not fulfill its obligations to ensure the right of access to functioning health facilities, goods and services on a non-discriminatory basis under international law[86], particularly for victims of sexual violence.

3. Sustainable Development Goals and the humanitarian-development nexus

113. With the nominal involvement of the Government in the public health sector, and international actors substituting for the responsibilities of State authorities in the face of the protracted humanitarian crisis, South Sudan appears to be off track in achieving the SDG goals by 2030, including in addressing in earnest the security, clinical, economic and social barriers for survivors of sexual violence to access medical care.

114. The 2030 Agenda for Sustainable Development has reinforced global health as a political priority and a critical means to ending poverty, promoting peaceful and inclusive societies, and protecting the environment.

115. SDG 3 (to "ensure healthy lives and promote well-being for all at all ages") includes as major targets the achievement of universal health coverage, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all. While SDG 3 is pivotal, several other SDGs and their targets are critical from the perspective of survivors of sexual violence. SDG 5 (to "achieve gender equality and empower all women and girls"), for example, contains a target to "[e]nsure universal access to sexual and reproductive health and reproductive rights."

116. In this regard, HRD found that there is a need to enhance joint accountability between national and international partners, for delivering value-for-money and sustainable results for survivors of sexual violence. This could be achieved through the development of SDG follow-up and review processes that are open, inclusive, participatory and transparent for all people, in a manner that leaves no one behind, and which monitor, track and evaluate progress on a regular basis in the health sector at the national and sub-national levels.

IX. Response from the Government of South Sudan

117. As per the Policy Directive on Public Reporting by Human Rights Components of United Nations Peace Operations, UNMISS and OHCHR shared an advance copy of the present report with the Ministry of Foreign Affairs and International Cooperation, for comment and input regarding actions already taken or that may be planned to address the concerns raised by the report. In correspondence dated 11 May 2020, the Ministry of Foreign Affairs informed UNMISS and OHCHR of the reply of the Ministry of Gender, Child and Social Welfare.[87] The Ministry describes the report as "timely" and providing "a true picture" of the challenges faced by CRSV survivors, including with regard to access to health services. It also "acknowledge[d] the challenges involved in addressing crimes of

[85] http://documents.worldbank.org/curated/en/236571543237264655/text/Concept-Project-Information-Document-Integrated-Safeguards-Data-Sheet-Protection-of-Essential-Health-Services-Project-P168926.txt
[86] For an analysis of these international legal obligations, *see infra* Annex 1.
[87] Republic of South Sudan, Ministry of Gender, Child and Social Welfare, *Submission of the initiatives of the Government of South Sudan on access to health for survivors of conflict related sexual violence*, Juba, 11 May 2020. *See infra* Annex 2.

sexual violence and related impunity" and expressed its appreciation for the support provided by national and international partners.

118. Furthermore, the Ministry of Gender enumerated the actions already taken by the Republic of South Sudan with regard to CRSV, including the adoption of Action Plans to address CRSV by the SSPDF, SPLA-IO/RM and SSNPS. The Ministry also highlighted measures it has taken specifically to address access to health care for survivors of sexual violence, including the establishment of one-stop centres at hospitals; the development of standard operating procedures (SOP) for GBV prevention, protection and response; and the creation of a draft GBV Bill for consideration by the national legislature. However, despite benefiting from international support including from the United Nations, the Ministry underscored the lack of funding as one of the main obstacles to scaling up its responses to survivors of sexual violence.

X. Conclusion and recommendations

119. Since the outbreak of conflict in December 2013, civilians have borne the brunt of the violence in South Sudan. CRSV has been widespread and pervasive, and deliberately used as a weapon of war to destroy the social fabric of communities and to forcibly displace civilians. The survivors and health care workers interviewed for this report described time and again the devastating impacts of CRSV, both in terms of physical and psychological harm, as well as the challenges in accessing health care and psychosocial support in the specific context of South Sudan.

120. HRD identified four major mutually reinforcing obstacles which continue to prevent CRSV survivors from exercising their fundamental right to health. Inadequate Government budgetary allocations to the public health sector have led to a disproportionate reliance on international donors and international health service providers. The trickle-down effect of these funding dynamics has impacted the availability of public health care services, which has compounded the consequences of the armed conflict on the health care system. Challenges related to the accessibility of health care services are a major factor constraining survivors' ability to obtain much-needed care, while issues arising from a general lack of health service readiness mean that, even where survivors are able to access health care, the range and quality of services available are often limited. On a broader level, social barriers created by the high level of stigmatization of sexual violence often lead survivors to seek care only after the development of medical complications.

121. Throughout its investigation, HRD encountered health professionals, both national and international, working tirelessly to assist civilians, including survivors of sexual violence, in accessing medical and psychosocial care, despite a myriad of practical challenges. They also do so in the face of significant risk, as attacks against health and humanitarian facilities and personnel have become a common feature of the conflict. It is critical that the international community continue to support the efforts of health professionals in South Sudan.

122. HRD considers that appropriate adjustments to the provision of health service delivery would increase survivors' access to these services, and provide for the longer-term development of the public health sector in South Sudan. To that end, the Government should prioritize the public health care sector, including through increased budgetary allocations, in order to meet its obligations as the primary duty-bearer responsible for promoting and protecting the rights of all persons in South Sudan, including the right to health.

To the Government of South Sudan:

- Substantially increase budgetary allocations for the public health sector above the current 1.2 per cent – considering that in order to meet international targets, 15 per cent of the fiscal year budget should be allocated to the public health sector; and strengthen the capacities of public health facilities and health workers.

- Significantly improve access to and delivery of health services, especially on sexual and reproductive health on an equitable basis at the community level.

- Ensure that competent national prosecutorial and judicial authorities investigate, prosecute and try individuals bearing responsibility, including those in positions of command and control, for violations and abuses of international human rights law, and violations of international humanitarian law, including CRSV and attacks against medical personnel and facilities.

- Ensure that victims have access to comprehensive programmes addressing immediate and long-term health and psychological needs.

- Conclude the process of accession to the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and their Optional Protocols by transmitting to the UN Secretary-General the instruments of accession.

To international donors and partners:

- Strengthen the development, humanitarian and peace nexus, in particular between projects providing medical responses for survivors of sexual violence and programmes addressing structural shortcomings in the public health sector, with regard to sexual and reproductive health care.

- Use existing multi-donor funding mechanisms to support the Government of South Sudan to establish an inclusive, participatory and transparent follow-up and review mechanism to monitor, track and evaluate progress in implementing the SDGs (particularly SDG 3 and SDG 5) at the national and sub-national levels.

- Support measures to prevent CRSV, including mechanisms to ensure accountability for perpetrators and to raise awareness about CRSV prevention and response amongst parties to the conflict, for example through the implementation of the Action Plans of the SSPDF, SPLA-IO/RM and SSNPS to address CRSV.

To Government, civil society and international actors:

- Increase efforts to overcome social barriers at the national and grassroots levels, through sensitization activities to empower key influencers, such as religious and community leaders, to change social norms contributing to the stigmatization of survivors.

Annex 1: Legal framework

1. International humanitarian law

1.1. Applicability

1. International humanitarian law applies to the non-international armed conflict in South Sudan.[88] The current peace in South Sudan remains fragile, with many of the components of the pre-transitional phase as provided for in the R-ARCSS yet to be implemented. A resumption of hostilities therefore cannot be discounted. In these circumstances, international humanitarian law may be considered to continue to apply.

2. South Sudan is party to the four Geneva Conventions of 1949 and to the Additional Protocols II and III to the Geneva Conventions, and has incorporated the Geneva Conventions and their Additional Protocols into domestic law.[89] Under international law, South Sudan is responsible for all violations of international humanitarian law, including customary international humanitarian law, committed by its armed forces or those acting under their direction or effective control. It is also obligated to investigate serious violations of international humanitarian law, and to ensure full reparation for loss or injury caused by the State or those acting under its effective control or direction.

1.2. Prohibition of sexual violence

3. All parties to the conflict are obligated to abide by core principles of international humanitarian law applicable in non-international armed conflicts, including the principles of distinction, proportionality and precaution. All persons who do not take a direct part or who have ceased to take part in hostilities should be treated humanely in all circumstances, without any adverse distinction founded, inter alia, on sex. Rape and other forms of sexual violence; torture, cruel or inhuman treatment and outrages upon personal dignity, in particular humiliating and degrading treatment; arbitrary deprivation of liberty; and pillage are prohibited.

1.3. Respect and protection of medical personnel and facilities

4. At all times, parties to the conflict must distinguish between civilian objects and military objectives and are prohibited from directing attacks against civilian objects. More specifically, parties to conflict must comply with their obligations to ensure respect and protection of all medical and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, and hospitals and other medical facilities.

2. International human rights law

5. The Republic of South Sudan is a party to the African Charter on Human and Peoples' Rights; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol; the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its Optional Protocol; and the Convention on the Rights of the Child (CRC),

[88] *See* in particular the Annual Report 2013 at 200 and press release of 6 January 2014, https://www.icrc.org/eng/resources/documents/news-release/2014/01-06-south-sudan-juba-petermaurer-president-visit.htm; Annual Report 2014 at p.204; the Intercross blog interview with the International Committee of the Red Cross of 12 June 2015, http://intercrossblog.icrc.org/blog/interview-with-head-of-delegation-in-southsudan; Annual Report 2015 at p.208; Annual Report 2016, at p.195; Human Rights Council, Report of the Commission on Human Rights in South Sudan, 31 January 2020, A/HRC/43/56, Annex III, para 4. https://www.ohchr.org/EN/HRBodies/HRC/CoHSouthSudan/Pages/Index.aspx

[89] Geneva Conventions Act of 2012.

the Optional Protocol to the Convention on the Rights of the Child on Involvement of Children in Armed Conflict and the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.[90] Under this international human rights law framework, which applies both in times of peace and armed conflict, South Sudan is legally bound to respect, protect, promote and fulfil the human rights set out in these instruments of all persons within its territory and subject to its jurisdiction.

2.1 Preventing human rights violations and abuses, including all acts of sexual violence

6. South Sudan has the obligation to prevent all acts of rape and other forms of sexual violence, torture and inhuman or degrading treatment, and abductions, as well as looting of civilian property; to take effective measures to prevent and promptly investigate violations and abuses of international human rights law; and to ensure accountability for those responsible for these acts.

2.2 Right to health

7. The human right to health is recognized in numerous international instruments. Article 25 of the Universal Declaration of Human Rights establishes that everyone has the right to a standard of living adequate for their health and of their family.[91] The Convention on the Elimination of All Forms of Discrimination against Women requires the elimination of discrimination against women in health care, as well as guarantees of equal access for women and men to health care services.[92] It also requires States Parties to enact and enforce laws and policies that protect women and girls from violence and abuse, and to provide for appropriate physical and mental health services. According to the Committee on the Elimination of Discrimination against Women, States Parties should allocate adequate resources and adopt effective measures to ensure that victims of gender-based violence, in particular sexual violence, have access to comprehensive medical treatment, mental health care and psychosocial support.[93] Throughout the Convention on the Rights of the Child, States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. The CRC requires States Parties to strive to ensure that no child is deprived of their right of access to health care.[94]

2.3 Progressive realization of the right to health

8. International human rights law provides that States shall take steps, to the maximum of their available resources, to progressively achieve the full realization of the right to health, and therefore acknowledges constraints that may arise from a lack of available resources. However, while recognizing these constraints, international human rights law also imposes on States various obligations, which are of immediate effect, such as to guarantee the right to health without discrimination of any kind and to take the necessary steps towards the full realization of this right. A State's unwillingness to use the maximum of its available resources for the realization of the right to

[90] In July 2019, the South Sudan Transitional National Legislative Assembly (TNLA) ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and their Optional Protocols, related to the establishing of individual communication mechanisms. The instruments of accession have yet to be transmitted to the UN Secretary-General, and, therefore, South Sudan is not yet formally a party to these specific treaties.

[91] Even if it is not still into force for South Sudan, the contents of the provisions of the International Covenant on Economic, Social and Cultural Rights that has been ratified by the TNLA, are relevant for the interpretation of the right to health enshrined in CEDAW and CRC. In this connection, Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes the right to the enjoyment of the highest attainable standard of physical and mental health.

[92] *See* Article 12.

[93] CEDAW General Recommendation No 30 on women in conflict prevention, conflict and post-conflict situations (CEDAW/C/GC/30), para. 38(e).

[94] *See* Article 24.

health would amount to a violation of this right. If resource constraints render it impossible for a State to comply fully with its obligations under the right to health, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, these obligations. Hence, all States, including those that have been through a devastating armed conflict, shall provide adequate resources to meet their obligations in relation to the right to health. Despite its fragile economic situation, under international law, South Sudan is not exempted from taking all necessary steps to ensure the progressive realization of the right to health.

2.4 Minimum core content obligations

9. Furthermore, States have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of the right to health. Thus, even if the situation of non-international armed conflict may reduce available resources, this does not exonerate the Government of South Sudan from taking the necessary steps with a view to achieving the realization of a minimum core content obligations of the right to health.

10. With regard to the right to health, the minimum core content includes the obligations to ensure *inter alia* the right of access to functioning health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups; to provide essential drugs; to ensure equitable distribution of all health facilities, goods and services; and to adopt and implement a national public health strategy and plan of action.

2.5 International obligations of States Parties to the International Covenant on Economic, Social and Cultural Rights

11. To reduce inequalities in accessing health care between and within countries, States Parties to the International Covenant on Economic, Social and Cultural Rights are advised, depending on the availability of resources, to facilitate access to essential health facilities, goods and services in other countries, wherever possible and to provide the necessary aid when required.

12. The Committee on Economic, Social and Cultural Rights in its General Comment no. 14 (2000) underlines the obligation of all States Parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health.

2.6 Right to health in territory under the control of non-state actors

13. Under the international human rights framework, the Government of South Sudan bears the primary duty to protect and safeguard the well-being of the persons in its territory and retains residual obligations towards members of its population living in territories under the control of SPLA-IO/ RM, even though it may not exercise effective control over these territories and may be unable to implement, or be prevented from implementing, its human rights obligations. For instance, the Government should take measures to seek international assistance for those territories and populations, and to ensure that international agencies are able to operate without any administrative obstacles.

14. Under certain circumstances, in particular where an armed group with an identifiable political structure exercises significant control over territory and population, non-State actors are obligated to respect international human rights.[95] It may include being responsible, as a *de facto* authority, for

[95] *See, e.g.,* CEDAW General Recommendation No. 30., para. 16.

ensuring respect for economic, social and cultural rights of persons within its area of control. Therefore, depending of the circumstances and context, armed non-state actors, such as SPLA-IO/ RM, may also be obligated to respect international human rights law in the territories under their control, including the right to health.

3. Domestic legal framework

15. Certain conduct amounting to serious violations of international human rights or humanitarian law, including rape, also constitutes a crime under South Sudanese domestic law. The right to physical integrity is protected by the Constitution and the Penal Code Act of 2008. Additionally, in 2012, South Sudan incorporated the provisions of the four Geneva Conventions and their Additional Protocols into domestic law; accordingly, South Sudanese courts are empowered to prosecute breaches of Common Article III of the Geneva Conventions, including for war crimes. Moreover, domestic military law provides for the criminal prosecution of acts committed by members of the SSPDF against civilians.

16. The transitional constitution of the Republic of South Sudan also recognizes under article 31 that all levels of Government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.

Annex 2: Response from the Government of South Sudan

REF: ACCESS TO HEALTH SERVICE FOR SURVIVORS OF CONFLICT RELATED SEXUAL VIOLENCE (CRSV) IN SOUTH SUDAN

1. INTRODUTION:

Ministry of Gender, Child and Social Welfare (MGCSW) received a study report conducted by UNMISS on access to health services for survivors of conflict related sexual violence in South Sudan. The report was forwarded to the Ministry of Gender, Child and Social Welfare by the Ministry of Foreign Affairs and International Cooperation (MFA&IC) for comments and input about actions taken or to be taken by the MGCSW in addressing the short comings in the study findings. The Ministry acknowledges the challenges involved in addressing crimes of sexual violence and related impunity and appreciates the support of the national and international partners. The Ministry is also encouraged by the support offered by the United Nations Mission to South Sudan (UNMISS). The Ministry takes this opportunity to thank UNMISS for the study conducted on "Access to Health services for Survivors of Conflict Related Sexual Violence (CRSV) in South Sudan." The report is timely as it gives a true picture of what challenges CRSV survivors experienced during the two conflicts. This includes the challenges and multiple factors that inhibit CRSV survivors' access health services or other supportive services. The three States selected for the study; Central Equatoria, Western Equatoria and Unity reflect a true image of what challenges the community and/or CRSV survivors experience not only in access to health services but also services for protection, prevention and access to justice.

2. ACTION TAKEN BY REPUBLIC OF SOUTH SUDAN:

The Republic of South Sudan, determined to end all forms of conflict related sexual violence, has taken several measures to that effect including endorsing the United Nations "Declaration of Commitment to End Sexual Violence in Conflict" launched at the 68th Session of the United Nations General Assembly in September 2013; ratifying key international human rights instruments, notably the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) which has been finally endorsed by H.E the President of South Sudan and embodied the following aspects strengthening domestic legislation; establishing and strengthening the South Sudan National Human Rights Commission and the Law Review Commission; agreeing on the prohibition of "any acts of rape, sexual abuse and torture". Those commitments were reinforced by the Cessation of Hostilities Agreement signed on 23 January 2014 and the Agreement on the Resolution of the Conflict in the Republic of South Sudan, signed on 17 August 2015 and the last Revitalized Agreement on the Resolution of the Conflict in South Sudan, signed on 12 September 2018 in Addis Ababa, Ethiopia.

In line with its determination to end all forms of sexual violence, the President of the Republic of South Sudan signed on 11 October 2014 a Joint Communiqué with the United Nations Special Representative of the Secretary-General on Sexual Violence in Conflict (SRSG-SVC) on addressing Conflict-related Sexual Violence requiring that it takes concrete measures including enhancing the legal framework to address such crimes. The Joint Communiqué contains a set of practical and political commitments to end the use of rape and sexual violence in conflict and provides for specific action plans for the Sudan Peoples' Liberation Army (SPLA), South Sudan Peoples' Liberation Army in Opposition (SPLA-IOM) and the South Sudan National Police Service (SSNPS). The Joint Communiqué also seeks to ensure proper investigation of sexual violence crimes, the establishment of accountability mechanisms, the exclusion of perpetrators of sexual violence from amnesty provisions, and that sexual violence is explicitly addressed in the peace process as an aspect of the Cessation of Hostilities Agreement. The Joint Communiqué also highlights the need to improve the multi-sectoral response to ensure comprehensive services to survivors such as medical, psycho-social services, economic support, and access to justice.

3. ACTION TAKEN BY MGCSW:

GBV remains a threat for women during and after the conflict and there has been little progress in reducing incidents of GBV in South Sudan. The unchecked level of impunity for perpetrators of such crime remains a significant obstacle in effectively protecting and achieving redress for survivors. The survivors of sexual violence, like victims of other crimes, face difficulties when they decide to report due to limited services which include inadequate courts of law in certain areas, limited protection for victims/survivors and witnesses, fear of reprisals, lack of legal aid and limited psychosocial support and information on reporting system. The stereotypical attitudes and reasoning are a discriminatory barrier and a burden on survivors of sexual violence which have contributed to women being reluctant to access justice.MGCSW takes the lead in GBV prevention, protection and response at national level, whereas at the state level, the mandate is with State Ministries of Gender and Social Development. The State ministries collaborate with line ministries (MOH, MOJ, MOI,) UN agencies, development partners, and civil society organizations in addressing GBV and CRSV.

The MGCSW develops policies and strategies to ensure that gender issues are addressed in all government processes, post-conflict reconstruction, resource planning, and human resource development activities. The MGCSW undertakes advocacy alongside overseeing the execution of these policies in coordination with line ministries and other relevant stakeholders;\ support training of social workers and gender focal persons from line ministries on gender mainstreaming, human rights and psycho-social skills to handle cases related to GBV; ensures that structures are in place to prevent, protect and respond to GBV at all levels; develop programs addressing gender inequalities in South Sudan.

Standard Operating Procedures (SOP) for Gender Based Violence (GBV) Prevention, Protection and Response has been developed to help stakeholders and government institutions in their attempt to prevent, protect and respond to GBV. This document therefore sets clear systems, roles and responsibilities for all institutions involved in the prevention, protection and response to GBV in South Sudan. The MGCSW took the lead to develop the SOP with multi-sectoral approach that

applies a well-coordinated multi-sectoral approach in all GBV prevention, protection and response programs. With the survivor and her/his community (and their needs, rights, demands, and contexts) at its core, the multi-sectoral model argues that effective prevention, protection and response must consider each of these elements. Equal and active participation of community leaders, local authorities, women/girls and men/boys in GBV protection, prevention and response programs should be promoted. All service providers and stakeholders need to be accountable and responsible in respect.

It is hoped this document would be effective, and will take well-coordinated multi-sectoral and comprehensive approach in all GBV prevention, protection and response programs at the 14 Special Protection Units lead by Ministry of Interior.

The MGCSW with support from UNFPA hatched the idea of "One Stop Center" (OSC) where a GBV survivors can be seen and services provided under one roof. The first one-Stop Centre was established in 2012 at Juba Teaching Hospital (JTH)). Under this arrangement there is medical Doctors, psychosocial services provider and paralegal for access to justice. During the fiscal years 2017-18, 2018-19 and 2019-2020, 9 additional One Stop Centers were constructed at State hospitals and most are functional: Malualkon in Aweil State, Rumbek Hospital, Wau Hospital, Torit Hospital, Yambio Hospital, Kapoeta Hospital, Bor Hospital. Akobo Hospital, Malakal Hospital,

Generally a One Stop Centers (OSCs) were intended to support women, children and men affected by violence, in private and public spaces, within the family, community and at the workplace. Women facing physical, sexual, emotional, psychological and economic abuse, irrespective of age, class, caste, education status, marital status, race and culture will be facilitated with support and redress. Aggrieved women facing any kind of violence due to attempted sexual harassment, sexual assault, domestic violence, trafficking, and other related crimes, acid attacks, witch-hunting who have reached out or been referred to the OSC will be provided with specialized services.

The challenges experience in managing the OSC: Expensive to do all the examinations by laboratory. Only two doctors were trained in addition to two clinical officers and six social workers. Health workers on gender based violence should normally operate on a 24/7 basis but due to lack of support they work only in the morning. Subsequently, no service is provided to survivors during the night. Survivors have to pay 75 SSP for laboratory testing which they cannot afford. The lack of availability of Form 8 is another challenge that they have to deal with such as police asking survivors to pay money in order to obtain Form 8. There is no proper space for counseling and no emergency budget to support the survivors.

The MGCSW in collaboration with Ministry of Justice and Constitutional Development have establish a special Court for trial of cases of GBV/ CRSV and child abuse. The South Sudan Judiciary, has established a mobile court for trying GBV cases within the community.

Although all these structures and mechanism has been put in place, access to services and justice have been a challenge to many GBV/CRSV survivors due to multiple problems.

4. ACTION TAKEN FOR IMPLEMENTATION:

The MGCSW has developed a draft GBV Bill to reform and consolidate the law relating to gender based violence including domestic violence, intimate partner violence sexual violence offences. Once passed by the Parliament it will result in a law that is fair and that will ensures women and men safety; social justice; will address the issues of gender based violence including harmful customary and traditional practices; protection of children from child marriage; protection of human rights of members of the family and ensuring the law is enforceable and accessible to the South Sudan population. The GBV Law is in line with the Transitional Constitution of the Republic of South Sudan, 2011 (as amended) and international legal obligations of South Sudan.