Improving maternal and child health through media in South Sudan

Final evaluation
This report was written by Trish Doherty and Karen O’Connor. The authors thank Lois Aspinall, Sophie Baskett, Anna Colom, Samuel Dima, Dianne Janes, Dorothy Peprah, Manza Wakka and Sonia Whitehead.

BBC Media Action, the international development organisation of the BBC, uses the power of media and communication to support people to shape their own lives. Working with broadcasters, governments, other organisations and donors, it provides information and stimulates positive change in the areas of governance, health, resilience and humanitarian response. This broad reach helps it to inform, connect and empower people around the world. It is independent from the BBC, but shares the BBC’s fundamental values and has partnerships with the BBC World Service and local and national broadcasters that reach millions of people.

The content of this report is the responsibility of BBC Media Action. Any views expressed should not be taken to represent those of the BBC itself or of any donors supporting the work of the charity. This report was prepared thanks to funding from the UK Department for International Development (DFID), which supports the research and policy work of BBC Media Action.

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Right: Women in Maban invited the Our Tukul producers to attend their traditional ceremony
Cover image: Andira, 28-year-old mother of four, breastfeeds her new born baby in her home in Gurei, Juba. Next to her is her second-born son
EXECUTIVE SUMMARY

“Our culture encourages women to have children; if you produce [babies] you will be a lucky woman at home, but if you don’t produce [children] your husband will divorce you.”

Health worker, Western Equatoria State, formative research, 2012

Following decades of civil war in the region, South Sudan lacks a functioning healthcare system and has some of the worst maternal and child health indicators in the world. This, combined with cultural expectations for women to begin reproducing at a young age, makes reproductive, maternal, neonatal and child health (RMNCH) one of the biggest development challenges facing the newest country in the world, alongside its ongoing humanitarian needs. By January 2017, more than 3 million people had been displaced by conflict; and nearly 4.8 million people were in urgent need of food assistance.

Funded by DFID under the Global Grant project, BBC Media Action produced a weekly radio health magazine programme, Our Tukul (Our House), from 2013 to 2016 in South Sudan. During the first year of the project, BBC Media Action also produced the weekly radio drama Life in Lulu under the Global Grant. These programmes were broadcast nationally, and were designed to influence knowledge, attitudes, discussion and social norms identified as most likely to drive the RMNCH behaviour of women and their families. BBC Media Action also produced public service announcements (PSAs) in 2013 and from 2015. All of this programming was broadcast across 16 radio partner stations in an evolving and often challenging context characterised by outbreaks of violence, mass displacement, food insecurity and escalating inflation.

In addition to Life in Lulu and Our Tukul, the project also focused on improving the capacity of local radio stations, with the ultimate aim of enabling local media to produce audience-driven health programming independently.

This report provides an evaluation of the project, drawing on findings from two quantitative surveys and five qualitative studies among target audience members, health workers, members of vulnerable communities and partner radio station staff. Unless otherwise indicated, the findings relate to Our Tukul.

Key findings from the research
Both Our Tukul and Life in Lulu reached 0.9 million people in South Sudan – a quarter of those with access to a radio. Around two-thirds of the overall audience reported listening to every second episode of the programme in 2016, equating to a regular audience of 600,000 people. Moreover, despite being one of BBC Media Action’s most challenging operating environments, research presented a generally optimistic picture of the perceived influence and value that audiences placed on the programmes. Research suggested that these programmes reached

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1 This reach was the same for both Life in Lulu and Our Tukul, but Life in Lulu was not part of the Global Grant at the time this was measured (July 2016), focusing on issues around conflict and social cohesion instead.
equal numbers of people who had been recently displaced and members of more settled populations. They also reached an audience that was representative of South Sudan’s overall population in terms of gender and age. However, people with no schooling were underrepresented in the programme’s audience as they were also more likely to lack access to a radio: of the survey respondents lacking access to a radio, 75% had received no schooling at all.

Listeners’ engagement was driven by *Our Tukul*’s realism, featuring the daily lives of people, the expert advice of Dr Mark, whose approachable manner helped audiences engage and trust the information, and the female presenter Betty Liyo. Early feedback indicated that the use of Simple Arabicvi prevented some audience members from grasping the detail of the content. Consequently, local programmes in the Zande, Dinka and Latuko languages were introduced in 2015.

Audiences reported gaining health knowledge from *Our Tukul*. The most commonly reported learning related to practices that do not require access to a health facility, such as knowing about the benefits of colostrum (first milk), and the importance of exclusive breastfeeding. However, *Our Tukul* provided new knowledge, or reinforced existing knowledge, across all the RMNCH behaviours. Of the 0.9 million people who listened to *Our Tukul* in South Sudan, approximately 78% felt that they had learned a lot or a bit from the programme on issues relating to antenatal care, birth preparedness and immediate or exclusive breastfeeding.

Listeners reported making some changes as a result of what they heard on the programmes, despite significant challenges. They reported making changes to their behaviour at home – for example, taking more rest during pregnancy or starting breastfeeding immediately. However, the realities of displacement, financial capacity, food scarcity and intermittent health service provision were insurmountable for many listeners, making it difficult to practise some of the healthy behaviours covered by programming, such as giving birth at a health facility.

Nearly four in 10 listeners (38%) reported discussing health practices with others. But the qualitative research showed that the challenging context made even conversations in the household difficult for some women, as some were reluctant to discuss issues relating to RMNCH to avoid putting additional financial strain on their family.

The local radio station partners involved in this project demonstrated resilience and the ability to absorb capacity-strengthening support even in the context of a deteriorating economic and security situation. They reported changes in their managerial, editorial and journalistic skills as a result of the training provided through BBC Media Action. The views of radio station staff on the utility of the training appeared to be consistent with the perceptions of some listeners, who reported notable positive differences in the stations’ output, such as the content of the programmes being more specific to the needs in the community. However, the sustainability of these changes in a humanitarian context is questionable. There is still work to be done on increasing the capacity of these radio stations to generate revenues, retain staff and ensure that training benefits are not lost with staff turnover.
I. INTRODUCTION

This report presents a synthesis of all research and analysis completed under BBC Media Action’s Global Grant-funded health project in South Sudan from 2012 to 2017. Its main focus is to evaluate the project’s impact on development outcomes among audience members and media partners (media practitioners and organisations). Based on this evaluation, the report reflects on the project’s impact on each of eight priority health behaviours. Where relevant, this report draws on formative research and monitoring data collected throughout the project, as well as relevant data from external sources. More detail on the research strategy and methodologies used can be found in section 2.

Section 1 summarises the project, including its background, the health and media context of South Sudan and the project’s objectives and activities. Section 2 describes the research approach used to evaluate the project and section 3 presents and discusses the evaluation’s findings.

1.1 Project background

Emerging from Africa’s longest-running civil war, South Sudan – the world’s newest country – has faced obstacles to development that were overwhelming in both scale and complexity. Among many other challenges at the outset of this project, the country did not have a functioning healthcare system and bore some of the worst maternal and child health indicators in the world. vii

In 2011, South Sudan had the highest maternal mortality rate in the world, with 2,054 deaths for every 100,000 live births. At this time, a 15-year-old girl in South Sudan was more likely to die in childbirth than finish her secondary education. viii Furthermore, babies born in South Sudan were at even greater risk. For every 1,000 children born, 135 would not survive to the age of five. ix These dire statistics reflected the reality of more than 20 years of war; a period during which people had become used to surviving without proper medical attention.

After the Comprehensive Peace Agreement was signed in 2005, x the development of the health sector in South Sudan, and particularly reproductive health, was a key focus for the country’s Ministry of Health and international donors. xi Although progress has been made on South Sudan’s development, the challenges of building a health system from scratch with limited resources while facing constant threats to security are immense. Providing accessible healthcare to a dispersed population presented many difficulties in a country with very little infrastructure and where a lot of areas are inaccessible during the rainy season. Consequently, many women in South Sudan go through pregnancy and give birth with little or no medical care and without the information, resources and support that could help save their own and their children’s lives.

South Sudan’s media sector faces its own challenges. In 2016, the country was ranked 140 out of 180 countries on the World Press Freedom Index. xii Freedom of reporting is undermined by weak legal institutions and strong political pressures, as well as the constant threat of retaliation by armed groups. xiii At a press conference in August 2015, President Salva Kiir said: “Freedom of the press does not mean that you work against your country. If anybody does not know that this country will kill people, we will demonstrate on them.” It was later claimed that these words were
“quoted out of context”. However, according to Reporters without Borders, journalists in the country are consistently pressurised not to cover issues related to the sustained conflict between government and opposition supporters.

Radio is the single most important source of information for people in South Sudan. Surveys undertaken by BBC Media Action to assess the audience of selected rural community stations in 2010 found that radio was the most cited source of information for more than 85% of the population in rural areas, with community radio stations providing local information in local languages preferred over national stations. The development of the TV media has been hindered by the country’s poverty and limited electricity. In effect, the state-owned South Sudan TV has little competition.

Reflecting the country’s underdeveloped media sector, access to media was limited among South Sudan’s broad population in 2013. Despite continued challenges to the development of the media sector over the course of the Global Grant project, overall more people had access to radio, TV, mobile phones and the internet in 2016 than in 2013 (see figure 1).

Figure 1: Media access among the South Sudan adult population

<table>
<thead>
<tr>
<th>Medium</th>
<th>2013</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>41%</td>
<td>51%</td>
</tr>
<tr>
<td>Mobile phones</td>
<td>30%</td>
<td>47%</td>
</tr>
<tr>
<td>Internet</td>
<td>3%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Note: figures exclude those who answered ‘don’t know’ and those who did not answer.
Unequal access to radio

The overall increase in radio access in South Sudan since 2013 masked stark variance, with radio access in some areas declining in recent years. Access to radio ranged from 90% of the population in the state formerly known as Western Equatoria to just 26% of the population in Jonglei and Upper Nile.

While 51% of the population living in the former Upper Nile state had access to radio in 2013, recent conflict has displaced many civilians and disrupted lives, reducing radio access to just 26% of the population in that area in 2016. Former states such as Warrap, Jonglei and Lakes are predominantly rural and as such lack reliable power supplies – these states continued to lag behind others in terms of radio access. In 2016, around two-thirds of the population in these areas did not have access to radio. In contrast, radio access has increased among those living in the Equatorias, an area that had been more stable than other parts of the country until the outbreak of fighting in July 2016. This period of stability may have allowed for more development of the media sector, and associated increase in radio access.
1.2 Project objectives

BBC Media Action’s Global Grant-funded health project in South Sudan was designed to support improved RMNCH by increasing the uptake of healthier behaviours and practices, particularly among women of reproductive age (15–49 years), their husbands, and other key influencers of health decision-making. The project sought to harness mass media and interpersonal communication (IPC) to address these issues.

### BBC Media Action’s approach to health communication

<table>
<thead>
<tr>
<th>BBC Media Action believes that health is influenced by many factors – some of which communication can influence, some of which it cannot. People’s health is determined by where they live, their society and their socio-economic position within it, as well as the health services that they are able to use. Critically, BBC Media Action believes that health behaviours are affected by people’s own attitudes and knowledge, as well as those of others around them.</th>
</tr>
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<tr>
<td>designed to trigger discussion and challenge social expectations.</td>
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</table>

Integral to BBC Media Action’s approach to health communication is the use of quality research to inform, evaluate and adapt communication – using different types of media and communication as well as partnership working. Project teams develop communication objectives as part of theory of change workshops, with extensive input from senior health advisors and research teams. These are reviewed periodically throughout project cycles to focus creative efforts.

<table>
<thead>
<tr>
<th>BBC Media Action believes that communication offers great potential to accelerate progress towards a healthier world. It recognises the need to move beyond the idea of health communication as top-down “messaging” to something that encompasses dialogue and respects the opinions of those most affected by particular health challenges. Drawing from health communication theory and audience research, the organisation harnesses the power of communication in diverse ways – from face-to-face, community-based interventions to mass media programming.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBC Media Action’s approach to health communication projects and research draws on academic and practitioner literature and guidance, and organisational experience in this field, including audience research. The organisation focuses on drivers of change in health that may be influenced through media and communication, such as knowledge, discussion or efficacy.</td>
</tr>
</tbody>
</table>

The project was designed based on an identified lack of knowledge, understanding and practice of healthy RMNCH behaviours among the broad South Sudanese population. The majority of women in South Sudan were not practising (and were often unaware of the necessity of) key RMNCH behaviours, including: attending antenatal care, delivering babies at a health facility with a skilled birth attendant present, essential newborn care practices, exclusive breastfeeding and immunisation. The project also sought to address the lack of understanding around birth spacing and early pregnancy, countering some unhelpful traditional beliefs.

2 Defined as self-belief in one’s own capacity to do something; for example, a mother feeling confident to attend an antenatal care check at a health facility or to discuss saving for birth with her partner.
To support the overall aim of improved health outcomes, the project aimed to address low levels of health awareness and accurate coverage of health issues by the media in South Sudan, a gap exacerbated by a lack of trained and professional journalists in the country. It also aimed to support increased information-sharing between members of government, media organisations and civil society, as well as supporting government agencies to support RMNCH outcomes.

The overall objectives of the project in South Sudan were to:

- Use effective mass media communication tools to shape knowledge, attitudes, norms, self-efficacy and societal support for change around key RMNCH issues
- Build the capacity of government agencies, national and local media and non-governmental organisations (NGOs) to engage in effective health communication on RMNCH issues

The project objectives changed substantially during its duration due to the changing needs of the South Sudanese people and project implementation limitations based on the security situation. However, the overall objectives remained focused around the key goal of improving RMNCH outcomes in South Sudan.

This project’s initial (2012) theory of change is outlined in figure 2. It shows the expected changes at audience, practitioner, organisation and systems level, arising from the mass media and capacity-strengthening interventions intended at the outset of the project. As a result of external factors limiting the implementation of key project activities, the theory of change was revised in 2013 (see appendix 2). The updated version took into account several key factors, including the capacity of partner stations, language issues, supply-side limitations and changing audience needs.

Manuel Adie, mother of two, talks about her experience of using diarrhoea treatment to save her younger child
Figure 2: South Sudan Global Grant health project’s initial theory of change

**Priority health behaviours to be addressed:**
- Uptake of antenatal care (ANC): only 17% of women attend four ANC visits
- Delivery at home instead of at a health centre: 87% of women deliver at home
- Delivery with a skilled birth attendant: only 17.2% deliver with a doctor or nurse-midwife
- Lack of essential newborn care for a baby and for the mother after delivery
- Low incidence of exclusive breastfeeding: only 44% of children are breastfed up to six months
- Lack of understanding about the health implications around birth spacing and early pregnancies

**Media and communication challenges:**
- Lack of trained and professional journalists
- Low awareness of health issues within the media
- Lack of health information-sharing between government, media and civil society
- Lack of capacity within government agencies to support reproductive, maternal, newborn and child health (RMNCH) outcomes

**Objective 1**
To use effective mass media communication tools to shape knowledge, attitudes, norms, self-efficacy and societal support for change around key RMNCH issues

**Activities:**
- Weekly radio magazine programme
- Weekly radio drama
- Public service announcements
- Local-language radio discussion programmes

**Assumptions:** The selection of these outputs is based on theoretical assumptions about the effectiveness of particular radio formats in increasing knowledge, influencing social norms and self-efficacy, and increasing social support for uptake on RMNCH behaviours both in general, and in South Sudan.

**Objective 2**
To build the capacity of government agencies, national and local media and NGOs to engage in effective health communication on RMNCH issues

**Activities:**
- Capacity strengthening for eight partner radio stations in seven states focusing on:
  - Contributing packages to the BBC Media Action magazine programme
  - Producing local-language discussion programmes (making interactive health programming)
  - Delivery of thematic training on RMNCH issues and communication for radio journalists at the state level using resource people from state ministries of health and NGOs

**Assumptions:** The selection of these activities is based on the assumption that media and the government can contribute to improving RMNCH health outcomes through effective communication.

**Cumulative outcomes:**
- Increased knowledge of the key RMNCH behaviours, shifts in social norms and increased social support among target population
- Increased confidence in health-seeking among audiences, including the confidence to use available health facilities
- Increased audience-focused programming on RMNCH issues at partner radio stations
- Increased opportunities for interaction between the target population and service providers through the media
- Increased confidence among the target audience to hold service providers accountable in the media
- Increased capacity of the media in seven states to support RMNCH communication
- Increased communication opportunities between government health workers and non-governmental organisations in seven states to communicate effectively on RMNCH issues
- Improved communication about RMNCH among the population

**Assumptions:** The long-term impact and benefits of capacity strengthening may not be captured within the lifetime of the intervention
- Attributing behaviour change solely to BBC Media Action’s activities is challenging due to the large number of other RMNCH activities
- Supply-side development will continue to match demand
- Monitoring and evaluation is restricted by the security situation

**Impact:**
Improved RMNCH norms, confidence and behaviours leading to healthier populations.

**Audience:** Uptake of priority RMNCH behaviours by target populations in South Sudan, specifically in the areas of
- Family planning
- Antenatal care
- Birth preparedness
- Safe delivery
- Essential newborn care
- Postnatal care
- Immediate and exclusive breastfeeding
- Vaccinations for children

**Practitioner:** Increased RMNCH and social and behaviour change communication (SBCC) knowledge, skills, experience and capacity among media practitioners, and improved engagement between government and media on RMNCH.

**Organisation:** Increased number of collaborative media and government RMNCH communication initiatives.

**Systems and the enabling environment:** Improved accountability through increased public engagement with leaders and health service providers on RMNCH issues.
1.2.1 Changes to partnerships

**Capacity-strengthening approach:** The project initially proposed providing capacity-strengthening support to partner radio stations from the outset, but this ultimately proved too ambitious due to the needs identified and the resources required. From 2013 to the beginning of 2015 the project focus narrowed to providing on-the-job support and training to core staff working on *Our Tukul*. BBC Media Action continued to provide broadcast support to partner radio stations throughout the project, and full capacity-strengthening resumed in 2015.

**Working with leaders and health providers:** Over the duration of the project, working with health providers proved challenging. While BBC Media Action checked all its advice/messaging with sources such as the World Health Organization (WHO) and Unicef, there were instances where health providers gave information that contradicted the advice BBC Media Action had broadcast. For example, some doctors and healthcare workers advised giving infants water during the first six months of breastfeeding.

Project staff collaborated with the Ministry of Health through its health working groups, but in 2015 there was a gradual decline in the frequency of these meetings, as discussions focused on logistics related to delivery of medicines and vaccines, which was less relevant to the project. Ultimately, this limited the project’s potential to strengthen the capacity of government agencies and this element of the project’s objectives was deprioritised. Nevertheless, future health programming in South Sudan will need to work with leaders and health providers in order to achieve change.

1.2.2 Changes to programming

**Language:** *Our Tukul* and *Life in Lulu* were initially produced in both English and Simple Arabic. However, research conducted in 2014 indicated that these languages were not widely understood, particularly among key target groups (people with little or no education, who are poor, and who live in isolated rural areas). As a result, the focus was shifted to supporting partner stations to produce content in local languages, which resulted in *Our Tukul* also being broadcast in Dinka, Latuko and Zande.

**Content:** Key assumptions in the original theory of change were that both the media and the national government could contribute to improving health outcomes through effective communication, and that supply-side development would continue to match health service demand. These assumptions proved to be false. Despite large-scale health service interventions in South Sudan, such as the Health Pooled Fund, the quality of services and the standard of professional care continued to be huge challenges. As a result, the scope and content of the health radio programmes were adapted to better suit the needs of a population with limited access to healthcare services.

The programmes also responded to the evolving humanitarian crisis in South Sudan (see box entitled A challenging environment). While they continued to cover RMNCH issues, they also incorporated humanitarian issues and issues around financial management. From July 2014, *Life in Lulu* moved out of the Global Grant project and was funded by other donors to focus exclusively on humanitarian issues, peace and conflict resolution.

These amendments to the theory of change are reflected in the project activities and outputs, described below.
Figure 3: South Sudan Global Grant project timeline

- **JAN 2012**: Project launches
- **JUN 2012**: Capacity-strengthening partnerships with radio stations established
- **JUL 2011**: Comprehensive Peace Agreement signed
- **DEC 2013**: Civil war breaks out
- **AUG 2015**: President Salva Kiir signs peace agreement with rebels
- **JUL 2016**: South Sudan becomes independent
- **JUN 2016**: Partner stations supported to make local Our Tukul programmes
- **MAR–APR 2016**: Capacity strengthening evaluation – in-depth interviews and focus group discussions

**Qualitative**
- **MAR–MAY 2012**: Formative – interviews and focus group discussions
- **JUN–JUL 2013**: Community assessment – focus group discussions
- **APR 2014**: User testing – focus group discussions
- **AUG 2014–MAY 2015**: Longitudinal study – in-depth interviews and focus group discussions
- **FEB–MAY 2016**: Vulnerable populations study – focus group discussions

**Quantitative**
- **OCT 2012–APR 2013**: Baseline – survey
- **MAY–JUL 2016**: Omnibus survey

**Pre-2012**
- **JAN 2005**: Comprehensive Peace Agreement signed
- **JUN 2012**: South Sudan becomes independent
- **DEC 2013**: Civil war breaks out
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**2012**
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- **FEB 2013**: Magazine show Our Tukul and drama Life in Lulu start airing
- **SEPT 2013**: PSAs start broadcasting
- **APR 2014**: PSAs pause
- **JUL 2014**: Life in Lulu no longer Global Grant-funded but continues broadcasting

**2013**
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**PRE-2012**
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- **JUL 2016**: South Sudan becomes independent
- **JUN 2016**: Partner stations supported to make local Our Tukul programmes
- **MAR–APR 2016**: Capacity strengthening evaluation – in-depth interviews and focus group discussions
1.3 Project activities
To achieve its objectives, the project centred on several key activities and outputs. These included three main radio productions and partnerships with radio stations to strengthen their capacity. All project components, as well as the key national events that took place throughout the project, are depicted in figure 3 and described in more detail below.

1.3.1 Radio programming
The project initially had three main radio outputs: the magazine programme Our Tukul, the radio drama Life in Lulu and a series of PSAs that focused on specific RMNCH practices. Overall, these outputs aimed to increase knowledge of priority health issues, and improve behaviours and supportive social norms around these same issues – such as attending antenatal care and giving birth in a health facility.

The project particularly focused on antenatal care, birth preparedness, safe delivery and immediate and exclusive breastfeeding, as these issues were considered a priority. Topics such as vaccinations, family planning and postnatal care were also covered, though to a lesser extent. The programmes also responded to the immediate and changing needs of the population. They were broadcast across 16 partner radio stations (see appendix 1).

Magazine programme: Our Tukul
Our Tukul, broadcast from 2013 to 2016, was a 25-minute-long magazine programme that packaged interviews, opinion and expert health advice from around South Sudan into an interactive radio programme. It was produced by BBC Media Action’s South Sudanese production team in a mix of simple English and Simple Arabic.

Primarily focused on RMNCH issues, the programme adapted to include wider content in response to the 2013 conflict, incorporating features on humanitarian issues including key water, sanitation and hygiene behaviours, how to treat wounds and landmine awareness. The programme also covered subjects like financial management, bringing in financial advisers and speaking with families about how to manage money, how to plan and the importance of husbands and wives discussing these issues.
Radio drama: Life in Lulu
Life in Lulu was part of the Global Grant project until 2014. The 15-minute-long drama aimed to help people in South Sudan understand the importance of healthy maternal and child health practices. Like Our Tukul, Life in Lulu expanded to incorporate broader humanitarian issues in 2013, as described above. By echoing the experience of ordinary people across the country, the programme sought to motivate listeners to reflect on their attitude towards maternal health and adopt new behaviours.

From July 2014, Life in Lulu was funded by other donors to focus exclusively on humanitarian issues, peace and conflict resolution.

Public service announcements
A series of 24, five-minute-long bulletins were produced and broadcast over the course of the project. These provided specific information on key behaviours such as attending four antenatal care visits, men encouraging their wives to attend antenatal care visits, the importance of washing hands, and malaria prevention. The PSAs were initially produced in both English and Simple Arabic and were aired throughout 2013. PSA production was halted in mid-2014 to focus resources on strengthening the capacity to produce Our Tukul.

In 2015, BBC Media Action’s South Sudan team resumed scripting for two PSAs in local languages, one on safely delivering babies and one on family planning. Given the reality of limited service provision across isolated areas of South Sudan, these PSAs were specifically adapted to address the needs of people with limited or no access to healthcare services. They were broadcast in April 2016 on seven Catholic Radio Network partner stations.

Four additional PSAs were broadcast by March 2017, focusing on birth preparedness, including preparing for a safe birth, saving money for birth, arranging transport to a health facility and the importance of seeking the help of a skilled birth attendant.

Zuhur Fauzi, Our Tukul producer, interviews 31-year-old mother of two, Siti Sebit, at her home in Gudele, Juba. Siti describes how Our Tukul has positively influenced her approach to exclusive breastfeeding, antenatal check-ups and diarrhoea prevention.
1.3.2 Capacity strengthening with media partners

In 2012, BBC Media Action started working with seven Catholic Radio Network stations and the UN national radio broadcaster, Radio Miraya. Through these partnerships, the project aimed to support local stations to produce their own health programmes. Initially, a team of BBC Media Action producers provided on-the-job support and training to station staff to enable them to produce local content that contributed to the national *Our Tukul* programme.

However, feedback indicated that skills gaps in the partner stations were too large and the technical, production and thematic training was not effective. In 2014, BBC Media Action revised its approach to capacity strengthening to focus first on strengthening the technical and managerial skills of the production team based in Juba, to achieve the key objective of providing quality and accurate health programming.

Broader capacity-strengthening activities were relaunched in 2015, including mentoring to enable stations to produce local content (starting with interviews and pre-recorded reports), eventually building up to them being able to produce their own local versions of *Our Tukul*. In 2016, BBC Media Action staff who were trained to work on the national programmes were seconded to local partner stations to provide training and support on producing their own health-focused magazine programmes.

The cost of providing this training and support was shared with the DFID-funded Girls’ Education South Sudan programme.

Children gather to watch the weight measurements of newborn babies as an *Our Tukul* producer records a story
A challenging environment

South Sudan is a difficult environment in which to work. While the country and its health services are largely dependent on donor NGO support, national and international aid workers face threats to their safety. The country ranks alongside Afghanistan, Pakistan, Somalia and Syria as one of the most dangerous countries for civilian aid workers to work in, according to the 2016 Aid Worker Security Report. xxi

Throughout the course of the project, BBC Media Action (and many other NGOs) worked against a backdrop of economic and social instability, poor service provision and a declining security situation. The project started in the aftermath of South Sudan’s independence in 2011, which promised a better life for people and was supported with encouragement and funding from multiple private and publicly funded donors. However, over the course of project implementation, the country’s humanitarian, economic and civil society infrastructures deteriorated.

The outbreak of violence in December 2013 exacerbated an already fractured political and social landscape. During the conflict in 2013–2015, 2.2 million people were displaced, according to UNHCR. xxii Attempts to restore peace with the Transitional Government of National Unity were quashed in July 2016, when fighting broke out in Juba for four days and the then first-vice president fled the country. The security situation in the rest of South Sudan continues to be precarious.

Day-to-day life in South Sudan, notwithstanding the security situation, is difficult. As of September 2016, inflation stood at 700% – with a weakening South Sudanese pound and insecure trade routes having drastic consequences on the price of goods and services. xxiii

Estimates from the UN Food and Agriculture Organization (FAO) from June 2016 put 8.9 million people (of a 12 million-strong population) in urgent need of assistance, and 4.8 million as being food insecure, a situation expected to deteriorate to unprecedented levels in 2017. By January 2017, more than 3 million had been displaced by conflict. xxiv

As such, the implementation of the BBC Media Action Global Grant-funded health project coincided with both growing needs among the people of South Sudan and a decreasing capacity to respond to these needs. Many of the project’s initial intentions needed re-evaluating in the context of insurmountable barriers to implementation.

However, BBC Media Action believes that in a difficult and constantly evolving context such as South Sudan, radio programming is uniquely positioned to meet, and adapt to, the needs of people – even when other services are affected by conflict or a limited operating environment.
2. RESEARCH

Research was a core component of the project, despite the challenges of gathering data in South Sudan. The research portfolio was implemented by BBC Media Action’s Research and Learning group.

The programme of research was designed to:

- Inform project activities
- Monitor results and report to the aggregate-level Global Grant logframe (where possible)
- Evaluate the project against overall objectives and key individual outcomes based on BBC Media Action’s health communication approach (such as knowledge, discussion, social norms and practice)

Security risks and the costs of large-scale data collection meant that the amount of quantitative research implemented throughout the project was deliberately limited. Over the course of the project, BBC Media Action undertook five qualitative studies (including one evaluation of capacity-strengthening work with media partners). Although quantitative research was not planned initially, BBC Media Action looked for opportunities to collect quantitative data. As a result, one quantitative survey among the key target group of women of reproductive age was conducted in 2012, and questions were added to one nationally representative tracker survey (via omnibus) in 2016.

Qualitative studies were conducted throughout the project to shape the project and explore if, and why, any changes occurred in health outcomes. The project also used qualitative methodologies to explore the impact of capacity-strengthening among media practitioners (journalists) and media partners.

Due to limitations of the quantitative data (including small sample sizes among key target groups), only basic descriptive analysis was conducted to compare key outcomes (such as improved health knowledge and increased practice of healthy behaviours) between people exposed to BBC Media Action programmes and unexposed people.

This report synthesises findings from the research outlined above and presents these findings as an evaluation of BBC Media Action’s Global Grant-funded health project in South Sudan.

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3 The Global Grant logframe is the monitoring framework to which all countries within the Global Grant report annually. It includes several key indicators measured through cross-sectional household surveys. Due to accessibility and cost limitations in implementing quantitative surveys in South Sudan, it was not possible for BBC Media Action to report to the logframe annually or across all indicators.

4 To test whether differences between groups were significant (including between people exposed and those not exposed to BBC Media Action programming), significance testing was carried out using a T-test. Throughout this report, only differences between two groups where p=0.05 or less are reported as significant.
### Table 1: Overview of qualitative and quantitative research studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Data collection</th>
<th>Method</th>
<th>Criteria</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formative qualitative study</td>
<td>2012</td>
<td>19 focus group discussions (FGDs)</td>
<td>FGDs – women of reproductive age, traditional birth attendants, older women aged 40–60</td>
<td>Explore knowledge, attitudes, practices and social norms around the key health behaviours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23 in-depth interviews (IDIs)</td>
<td>IDIs – husbands, community health workers, hospital or health centre staff, opinion formers, government officials</td>
<td>Explore barriers and enablers to adopting these behaviours as well as the standard and quality of available health services</td>
</tr>
<tr>
<td>Quantitative baseline (note that programming went on air midway through this survey)</td>
<td>October–November 2012 (Yambio) March–April 2013 (Torit and Rumbek)</td>
<td>Household survey (n=1,644)</td>
<td>Women of reproductive age</td>
<td>Establish levels of knowledge, attitude and practice around key health behaviours</td>
</tr>
<tr>
<td>Qualitative community assessment</td>
<td>June–July 2013</td>
<td>18 FGDs, 5 IDIs</td>
<td>Women of childbearing age, husbands and older women in Yambio (former Western Equatoria)</td>
<td>Explore attitudes, practice and social norms</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Explore barriers and enablers to adoption of behaviours</td>
</tr>
<tr>
<td>Qualitative longitudinal study</td>
<td>2014–2015</td>
<td>19 participants interviewed over four waves</td>
<td>Women across four points in time</td>
<td>Longitudinal study of priority behaviours over time and the role of BBC Media Action programmes in behaviour change</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>FGDs with husbands and older women</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>IDIs with health workers at two points in time (Kerepi, former Eastern Equatoria)</td>
<td></td>
</tr>
<tr>
<td>Vulnerable populations qualitative study</td>
<td>February–May 2016</td>
<td>11 FGDs</td>
<td>Vulnerable communities in former Eastern Equatoria, Northern Bahr El Ghazal and Upper Nile, including pregnant women, new mothers, husbands and older women</td>
<td>Exploring priorities and information needs of vulnerable groups</td>
</tr>
<tr>
<td>Quantitative tracker survey (omnibus)</td>
<td>June–July 2016</td>
<td>Household survey (n=1,069)</td>
<td>National omnibus survey conducted in the accessible areas of all former 10 states of South Sudan with respondents aged 15+</td>
<td>Establish programme reach, levels of knowledge, attitude and practice around key behaviours and any association with exposure to project outputs</td>
</tr>
<tr>
<td>Capacity-strengthening qualitative evaluation</td>
<td>2016</td>
<td>6 FGDs, 22 IDIs</td>
<td>FGDs with audiences IDIs – staff from three partner radio stations, and BBC Media Action trainers and mentors</td>
<td>Evaluate the effectiveness of capacity-strengthening partnership with local radio stations</td>
</tr>
</tbody>
</table>
This report uses both quantitative and qualitative methods to examine the extent to which the project achieved its objectives. It does not aim to describe individual groups or factors in detail, but instead to identify patterns that can aid in understanding the influence of BBC Media Action project activities. A series of validity checks throughout the research process ensured that data collection and analysis was rigorous and robust. All quantitative samples were as nationally representative as possible (within the limitations of accessibility in areas affected by conflict) to create a cross-sectional ‘snapshot’ of the population at one point in time. Data was cleaned and weighted to account for any errors or limitations in data collection.

Nevertheless, the research limitations should be considered when interpreting the findings detailed in this report. The impact data was self-reported and self-attributed by respondents: it is only possible to understand what audiences themselves believed they learned from programming. Such data may be prone to under- or over-reporting. Quantitative analysis has not controlled for confounding factors – such as level of education, income or distance to a health facility – that may influence the health outcomes in question (such as a woman’s likelihood to attend antenatal care visits).

To account for some of these limitations, a mixed methods research approach was used. Qualitative methods were used alongside surveys to strengthen and validate findings, where appropriate. While qualitative methods did not provide nationally representative findings, they provided a more in-depth understanding of health-related engagement, knowledge, attitudes and behaviours. When brought together, these findings granted a more holistic account of the relationship between exposure to BBC Media Action’s programming in South Sudan and RMNCH outcomes.
3. EVALUATION FINDINGS

This section outlines findings from the evaluation of BBC Media Action’s health project in South Sudan. This includes performance against headline indicators monitored throughout the project, the reach of Our Tukul, feedback on audience engagement with the programme, and evaluation of the impact of the project (including both Our Tukul and capacity-strengthening activities) on key RMNCH outcomes.

As mentioned, the drama Life in Lulu stopped being part of the Global Grant project in 2014. Research into the drama is referred to where applicable. Otherwise, the findings below refer to the national radio magazine programme Our Tukul.⁵

3.1 Headline indicators

Figure 4: What did the project achieve?

Definitions:

**Adult population**
Those aged 15 years and above

**Potential audience**
All those who report having access to TV, radio or the internet in the household or elsewhere

**Audience reached**
Those who report having seen/listened to the programme(s) within the last 12 months at the point of data collection

**Audience regularly reached**
Those who report having seen/listened to at least every other episode of the programme(s) within the last 12 months at the point of data collection

**Outcome**
The percentage of viewers/listeners of BBC Media Action health programming who reported learning ‘a bit’ or ‘a lot’ about RMNCH from the programme

⁵ Due to the challenges of conducting research in South Sudan, BBC Media Action’s research efforts were focused on Our Tukul (which had been broadcasting consistently throughout the project). As such, the impact of the PSAs was not explored.
3.2 Audience reach and profile

Key insights

- Despite the challenging environment and limited access to media platforms among the population, *Our Tukul* reached 0.9 million people in 2016, its final year of programming (13% of the adult population aged 15 and above).

- People displaced by conflict continued to listen to *Our Tukul*: 14% of people who had had to relocate in the previous year had heard the programme.

- *Our Tukul*’s regular audience reflected the population in terms of age and gender distribution, although people with no education were less likely to have listened to it. Language barriers and limited radio access were likely to be the primary reasons for the limited reach of *Our Tukul* among this group.

This section outlines the reach and audience profile of the magazine programme *Our Tukul*. It was not feasible to include measures for the PSAs in the tracker survey.

3.2.1 Reaching audiences in a challenging context

One of the main advantages of media and communication-based interventions is the scale of the audience that can be reached through the broadcast media. As such, reach (the number of people who watch or listen to a programme) is a key measure of a media project’s success, though certainly not the only one.

*“When we were in Sudan, we had a radio at home. But since we came here, we have had nothing to buy a radio [with].”*

_Young woman, Maban, vulnerable populations study, 2016_

By the end of 2016, the programme was broadcast on 23 partner stations throughout South Sudan, with scheduling varying across each partner station, reaching all former 10 states. In the context of South Sudan, given the under-development of the media sector, the limited access to media among the population (particularly among the most isolated and vulnerable groups), and the large-scale displacement of people within the country, achieving broad listenership is a particular challenge.

Despite this, a total of 900,000 people listened to *Our Tukul* at least once in 2016. This equated to 13% of the adult population (aged 15 years and over) and 26% of those with access to radio. 

While qualitative research pointed to challenges with access among some displaced people, analysis of the endline sample showed that reach at a national level held up even among people who had had to move from their homes in the previous year.

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*Reach in millions is calculated by using Population Reference Bureau (PRB) estimates. However, PRB estimates do not take into account migratory movements. More than 1.4 million people have been displaced from South Sudan to neighbouring countries due to insecurity, according to UNHCR figures from December 2016. The survey was conducted in June 2016.*
BBC Media Action recognises that watching or listening to a programme once is unlikely to affect outcomes and that detectable impact requires frequent engagement with programme outputs. As such, it is hypothesised that people who watch or listen to BBC Media Action programming regularly are more likely to demonstrate impact as a result of the intervention. In the case of Our Tukul, around two-thirds of the overall audience reported listening to every second episode of the programme in 2016, which equated to a regular audience of 600,000 people.

In 2016 the reach of BBC Media Action’s drama Life in Lulu, addressing social cohesion issues, was also approximately 900,000 listeners, or 13% of the adult population aged 15 and above. In the 12 months preceding the survey in July 2016, three-quarters of Our Tukul listeners had also listened to Life in Lulu.

### 3.2.2 Audience profile

The project aimed to reach as broad a cross-section of the South Sudanese population as possible through Our Tukul. In particular, it aimed to engage pregnant women, women with a baby aged 0–9 months, the husbands of women of reproductive age, and older women who were influential in the community.

Figure 5 shows the demographic breakdown of Our Tukul’s regular audience in 2016 and compares it with the national population to assess how representative the programme’s audience was.7

Overall, Our Tukul’s regular audience reflected that of the population of South Sudan in terms of the distribution across gender and age groups. However, people with no education (a group that accounts for more than half of the South Sudanese population) were significantly under-represented among the programme’s audience – just 12% of those regularly listening to Our Tukul were in this group.

Findings from qualitative research suggested that radio access was particularly low among people with no education or low levels of education, and among people living in remote areas of the country. Furthermore, language may have been a barrier among this group, who predominantly speak local languages. Qualitative research with particularly vulnerable populations in the Equatorias and parts of the Bahr el Ghazals found that participants struggled to follow the programme because they did not speak Arabic fluently.

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7 National population statistics were based on the overall survey sample (which was nationally representative).
Figure 5: Demographic breakdown of Our Tukul’s audience (2016)

HOW REPRESENTATIVE IS BBC MEDIA ACTION’S AUDIENCE?

**Gender**
- Female: 53% (56% of sample)
- Male: 47% (44% of sample)

**Region**
- Jonglei: 6%
- Upper Nile: 3%
- Unity: 5%
- Warrap: 13%
- Western Bahr el Ghazal: 5%
- Western Equatoria: 7%
- Eastern Equatoria: 13%
- Central Equatoria: 20%
- Lakes: 12%
- Northern Bahr el Ghazal: 4%
- Eastern Equatoria: 4%

**Age**
- 15-24: 32%
- 25-34: 37%
- 35-44: 22%
- 45-54: 21%
- 55-64: 7%
- 65+: 1%

**Education**
- Completed college/university: 4%
- Completed secondary: 12%
- Completed primary: 11%
- Some primary: 27%
- No schooling: 54%

Note: figures exclude those who answered ‘don’t know’ and those who did not answer
The gender split in the sample population was weighted towards women (56% female; 44% male).

This may be due to a variety of factors relating to limitations of the household omnibus survey design and demography:

- The survey was fielded in May–July 2016. This is farming season in South Sudan, so some men were unavailable at the time of surveying.
- Many males were involved in the conflict at the time of surveying, which meant they were absent from the household for extended periods of time.

Despite this demographic split, the differences in the gender profile of Our Tukul audiences were not significant.** Even though access to radio in South Sudan was slightly higher among men (55% for men and 47% for women), women were as likely as men to listen to the programme.

Chi-square tests were used to test for significance. All differences reported as significant are significant at the 95% level (p<0.05).

### 3.3 Engagement with the programmes

**Key insights**

- Listeners to both programmes reported enjoying the stories they presented, particularly hearing about people like them.
- The involvement of a real expert in Our Tukul, the medical professional Dr Mark, was valued by listeners for his expert advice and approachable manner.
- Audience members appreciated the presence of a regular presenter on Our Tukul, who saw her as a trusted source of information.
- Language was a barrier to engaging with the programmes but simplification of the language content helped to resolve this issue.

Through Our Tukul and season one of Life in Lulu, the project aimed to contribute to audience members’ knowledge of RMNCH issues, to overcome unhelpful societal norms that influence health practices, and to increase social support around RMNCH among men and women of reproductive age. The following section explores how and why audiences in South Sudan engaged with the programmes, and looks at audience perspectives on them.

#### 3.3.1 Realism and trust

In South Sudan, audience members often expressed a desire to hear from an expert. On Our Tukul this was provided through a segment with a real doctor known to audiences as Dr Mark. Dr Mark responded to questions collected during the week through a voicemail service. Audience members trusted Dr Mark because of his status as a doctor and reported finding him easy to understand and approachable in manner.
Another core element of *Our Tukul* was the inclusion of stories and experiences of a variety of ‘ordinary’ people. This resonated with listeners, who frequently mentioned that they enjoyed hearing stories from people like them.

These stories were tied together by the programme’s regular presenter Betty Liyo. Audience members particularly valued her role, seeing her as a source of trustworthy information.

**The voices [on *Our Tukul*] are those of other people but their views are just like ours. It’s like we are the ones who talked.**

_Pregnant woman, Aweil, vulnerable populations study, 2016_

3.3.2 Language as a barrier to engagement

South Sudan is a multilingual country, with about 60 different languages spoken and no single language that unites the country. While the government of South Sudan has adopted English as the country’s official language, it remains the language of the educated elite and is not widely spoken or understood outside large towns. Simple Arabic is the most widely understood across the country but it is not all pervasive. Local languages predominate outside the country’s main centres and many people, particularly those among the broad section of society who have limited or no formal education, do not understand either Simple Arabic or English.

This language barrier was one of the key issues raised by audience members throughout the project. Community assessments conducted in 2013 found that listenership to *Our Tukul* was low, partly because of language barriers. For example, research participants in Yambio who mainly spoke Zande said they were unable to fully understand the content of *Our Tukul*, which, at that point, was broadcast in English and Arabic.

As a result of this feedback, the programme focused on simplifying the language used in Simple Arabic programmes and ceased production of English versions of the programme. Subsequent research among people for whom Arabic was not their first language indicated that they were better able to recall and understand some of the key points discussed on *Our Tukul*.

The language barrier also proved to be an issue for listeners to Life in Lulu. Listeners spoke of enjoying the stories portrayed in the drama and were able to recall certain characters. However, recall of specific learning points was limited, and not as frequent or as clear as learning recalled from *Our Tukul*.

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*Community assessments were conducted by Forcier Consulting on behalf of BBC Media Action in July and August 2013.*
In order for me not to add more problems, it is better for me to keep quiet about [things learned from Our Tukul].

Pregnant woman, Maban, vulnerable populations study, 2016

3.3.3 Discussing Our Tukul

Listeners discussing Our Tukul offers a dual indicator of success. Firstly, a listener discussing what they heard on the programme can be considered an indication of their engagement with the programme. Secondly, stimulating discussion of RMNCH issues was a key focus of Our Tukul as that is considered a precursor to adopting healthy behaviours, an important driver in BBC Media Action’s approach to health communication.

For example, the programme aimed to encourage women to discuss visiting a health facility for an antenatal care check-up or for a baby’s birth with their husband or families as soon as possible. Similarly, listeners were encouraged to make family plans to save to pay for transport to a healthcare facility. In an environment where money and resources were increasingly scarce, the programme’s emphasis on encouraging discussion around alternatives or how to use available resources was critical to supporting the uptake of this health behaviour.

Around two-fifths of listeners (37%) in BBC Media Action’s 2016 survey said that they had discussed the programme with someone else. However, qualitative research highlighted that when people’s lives are highly stressful – as a result of conflict, unemployment or financial instability – household dynamics and gender norms may not make open discussion possible.
3.4 Impact on audience-level health outcomes

Key insights

- Listeners to Our Tukul reported taking up behaviours that did not rely on a health service or going to a health facility – particularly breastfeeding practices. This reflected the context of limited health service provision and the ongoing humanitarian crises in South Sudan.

- Across the quantitative and qualitative studies, listeners reported that the programme provided new information, or reinforced existing information, around antenatal care, birth preparedness and breastfeeding.

  - The most widely reported learnings from Our Tukul on what a woman should do during pregnancy were needing to eat more nutritious food, attending four or more antenatal check-ups starting in the first trimester, and taking rest during pregnancy.
  - On preparing for birth, the most widely reported learning was arranging to deliver in a health facility, with a skilled attendant and to save money in advance.
  - On breastfeeding, starting within an hour of birth was by far the most widely reported learning, followed by the importance of colostrum and the fact that breast milk alone is sufficient nutrition for a baby’s first six months.

- Listeners attributed health behaviour change to Our Tukul: some participants spoke about feeding their newborns colostrum and exclusively breastfeeding after learning it from the programmes.

- However, qualitative research that followed the journey of mothers showed that progress was complicated, as one might expect in such a challenging context. People sometimes received contradictory information, forgot things they had learned, were talked out of healthy attitudes, lost confidence or changed their minds about what they wanted to do.

The project set out to improve knowledge and uptake of key health behaviours related to RMNCH, with a focus on antenatal care, birth preparedness, essential newborn care and breastfeeding. The programmes also covered other health practices related to postnatal care, sexually transmitted diseases, family planning and vaccinations.

Quantitative data was collected from the 2016 tracker survey, providing descriptive analysis across the key behaviours. The timing of the survey meant that it only measured the impact of Our Tukul, as Life in Lulu had moved on to focus on conflict and peaceful reconciliation and was funded outside of the Global Grant. The findings from this section therefore focus mainly on Our Tukul – the programme that was broadcast throughout the project, and for which most data was collected.
3.4.1 Antenatal care

According to guidelines provided by WHO, the ideal course of action for a pregnant woman is four, facility-based antenatal check-ups during pregnancy, which include immunisations, and blood pressure and urine checks. A woman should also receive iron and folic acid tablets and have access to a wide range of information and treatments. In effect, antenatal care attendance is a behaviour that has multiple potential benefits for mothers and babies. However, the 2010 South Sudan Household Health Survey indicated that a mere 40% of women who gave birth in the previous two years had attended at least one antenatal assessment, and only 17% had attended the recommended four check-ups.xxvii

Formative research for this project identified a number of barriers to antenatal attendance. These included: believing that antenatal care is only for the sick; the distance to a health facility and lack of money and/or transport to get there; a lack of time to attend (due to work and

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Case studies following women through pregnancy and early motherhood have been used to provide a more holistic picture of the pathway to change and the role of Our Tukul in a complex context.

These longitudinal case studies highlight instances of women having correct knowledge on key outcomes or an intention to practise a safe behaviour in one interview, only for a later interview to reveal that this knowledge had been forgotten or the intention had changed. This was attributable to a number of factors, including lack of financial or logistical support, contradictory information provided by medical professionals in health facilities, and a lack of healthcare services.

Accessing health facilities was challenging for the programmes’ audience members and the wider population in South Sudan. Formative research conducted in 2012 found that health workers had concerns that the supply side of the health system was not keeping pace with increases in demand. Those interviewed for this project spoke of facilities lacking equipment and basic medications, being understaffed and unable to provide a high quality of care.

“You get to the hospital [and it] is not well-equipped, not ready even to receive [a pregnant woman] and we start quarrelling with her there, then she becomes upset and so she is completely disappointed.”

Health worker, Yambio, Western Equatoria State, formative research, 2012

Research participants reported varying levels of access to adequate health services. For some, access to health facilities was not an issue – particularly in refugee or protection of civilian settings. For others, particularly in rural and remote locations, distance and lack of transport presented significant barriers to attending antenatal check-ups and delivering babies in a health facility.

“Most people don’t reach the hospital because of lack of transport... so many of them deliver [their babies] at home.”

Pregnant woman, Aweil, vulnerable populations study, 2016

A difficult path to behaviour change

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other commitments); a lack of understanding of the purpose of antenatal check-ups; and a preference for traditional birth attendants (reflecting both tradition and convenience).

The project aimed to support the uptake of antenatal care practices, including more women receiving at least four antenatal check-ups during pregnancy. It aimed to achieve this through increasing knowledge of the necessity of antenatal care for a pregnant woman and her baby, and of the benefits of attending four check-ups.

**Limited knowledge about antenatal care**

Overall, knowledge around antenatal care remained low among the broad population of South Sudan in 2016. In total, only 35% of survey respondents knew that a woman should attend at least four antenatal check-ups. Knowledge was significantly higher among women: 39% of female respondents knew that a woman should do this, compared with 31% of men.

Barriers to antenatal care continued to exist in South Sudan at the end of the project, and were not substantially different from those identified in the formative research. However, reflecting the hardship faced by many as a result of drawn-out conflict, women spoke of having less time to go to a health facility for antenatal care as food and money became increasingly scarce.

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9 Participants were not asked about when the check-up should happen, or with whom.

10 Chi-square tests were used to test for significance. All differences reported as significant were significant at the 95% level (p<0.05).
Learning about resting and nutrition
Over the last 12 months of the project, Our Tukul emphasised attending four antenatal care check-ups (starting in the first three months of pregnancy) and key elements of self-care such as eating more nutritious food and resting more during pregnancy. The research findings reflect this focus.

When asked “What have you learned from Our Tukul about what a pregnant woman and her family should do during pregnancy?”, listeners were most likely to spontaneously report the following:11

- A pregnant woman should eat more nutritious food (62%)
- A pregnant woman should attend four or more pregnancy check-ups (57%)
- A pregnant woman should attend a check-up within the first three months of pregnancy (44%)
- A pregnant woman should rest more (44%)
- A pregnant woman should avoid hard labour (44%)

“I heard a story about a woman who got pregnant and didn’t go for antenatal checks. It happened that she was having a sickness called ‘pneumonia’ and this sickness later killed her while giving birth.”

Pregnant woman, Torit, vulnerable populations study, 2016

More than two-thirds of listeners (70%) reported learning something about what a pregnant woman and her family should do during pregnancy from listening to Our Tukul (including 32% who reported learning a lot).

In qualitative research conducted in 2016, participants also recalled stories from Our Tukul around the importance of antenatal care, and how the segments in the programme reflected examples from their own community.

“Digging – even in pregnancy, from the first month to the ninth month – that’s what I used to do before… [Our Tukul] taught me about not doing heavy work on reaching five to six months of pregnancy.”

Woman, 25, longitudinal qualitative study, 2015

In the qualitative research, participants also reported learning about taking more rest during pregnancy, doing less hard work and eating more nutritious food. Some participants said these were their favourite topics discussed on Our Tukul.

11 The base was n=119, comprising all adults aged 15+ who reported listening to Our Tukul at least once in the 12 months before data collection.
In August 2014, Sarah was a 23-year-old farmer and was three months pregnant. She lived with her mother and father, her two children and her sister’s children. Sarah had received some primary education and had a radio in her household.

Sarah already knew that she should attend at least four antenatal check-ups to check on her health and that of her baby and to get vitamin supplements. During her pregnancy, Sarah reported being able to go to all four antenatal check-ups. She had a positive experience, saying she was attended by a trained midwife, not charged and received items for a safe birth, such as a clean razor blade to cut the cord.

Sarah reported learning about the antenatal check-ups from the health facility and from a card the facility gave her, which specified how often and when she should go for check-ups. She did not mention learning about check-ups from either the Our Tukul or Life in Lulu programmes.

However, Our Tukul helped Sarah to build on this knowledge. She reported learning about taking more rest and taking better care of herself during her pregnancy from the programme and reported being able to change her lifestyle to do less work as her pregnancy progressed.

“What I heard [from Our Tukul] was what we should do when we are pregnant. We shouldn’t do heavy work: you have to do a little work and not cut firewood, you have to wash light clothes only – not heavy ones. I also heard about personal hygiene – about the need to keep clean by bathing and wearing clean maternity dress.”

*Case study from the 2014–2015 longitudinal qualitative study conducted in Kerepi. ‘Sarah’ is not the participant’s real name.
3.4.2 Birth preparedness
Preparing for birth is critical to avoiding delays in receiving appropriate medical care, especially if complications occur during birth. This is particularly pertinent in South Sudan, where many people live long distances from the closest health facility and 81% of women deliver their babies at home. In formative research, BBC Media Action found mixed levels of awareness about the need for preparation before childbirth. The most commonly mentioned activities included cleaning the house, preparing food and soap, and having a clean razor blade and clean cloths ready. Planning for possible emergencies was rarely prioritised, in part due to a widespread sense of fatalism.

The project aimed to support the uptake of birth preparedness activities, both in terms of emergency preparedness (for women planning to deliver at home) and planning for giving birth at a health facility. Our Tukul aimed to support the uptake of the following behaviours, where possible:

- Saving money during pregnancy
- Planning transport to a health facility
- Arranging for a skilled birth attendant to be present during delivery
- Keeping contact numbers to call for help if there is an emergency during pregnancy
- Preparing clean instruments for umbilical cord care

Limited knowledge about birth preparedness
In 2016, survey participants were asked what, if anything, a pregnant woman and her family should do to prepare for the delivery of a child. Across each key birth preparedness practices, knowledge remained low. For example, only 28% of respondents mentioned saving money in advance for delivery as a key birth preparation. One in 10 respondents mentioned arranging transport either for a health facility birth (12%) or in case of an emergency (10%). Just 6% of respondents mentioned keeping contact numbers for getting support during labour or delivery if complications arise.

Men were significantly more likely than women to know that they should arrange transportation (16% of men compared with 9% of women) and keep emergency contact numbers (14% of men compared with 6% of women). This may be a result of higher levels of education, or possibly as a result of gendered responsibilities when it comes to preparing for birth.

Despite higher levels of knowledge among men, focus groups revealed that this did not necessarily translate into practice. Women reported that they were not always able to rely on their husbands to help with birth preparations and did not always have the necessary power to influence them.

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11 This question was not prompted – participants were asked about “anything else”.
12 This comparison was based on a small sample base of n=37 respondents (those who mentioned keeping emergency contact numbers). It should therefore be considered indicative only and interpreted with caution.
Research suggested that the most commonly practised birth preparations included preparing clean cloths for mother and baby (42%) and preparing food and drink (32%). Participants in the qualitative research said that these activities were less dependent on financial capacity, compared with preparations like arranging transport.

“There are men who don’t care for their wives… If their wives ask them for money for buying any essential need, they will say that there is no money and will promise to give the money the following day.”

*Pregnant woman, Aweil, vulnerable populations study, 2016*
Learning about birth preparedness from Our Tukul

While overall birth preparedness knowledge remained limited at the population level in 2016, almost three-quarters (73%) of Our Tukul listeners reported having learned about birth preparedness from the programme. Of these, 34% felt they had learned a lot about this issue.

The key elements of a birth plan that audience members reported learning about reflected the programme’s priorities during the last year of the project, including:

- Pregnant women should give birth in a health facility (56%)
- Families should arrange for a doctor, nurse, midwife or health worker with training to deliver the baby (51%)
- Families should save money in advance for a baby’s delivery (43%)
- Families should prepare a sterile birthing kit (33%) or sterilised blades for cord cutting (22%)
- Families should arrange transport to a health facility ahead of the birth (23%), or make arrangements for emergency transport if planning to deliver at home (16%)
- Families should keep the contact numbers of people who could help in an emergency, such as an ambulance, health worker or driver (19%)

Case study: Estella*

At the start of the longitudinal study in 2014, Estella was a 20-year-old housewife and was seven months pregnant. Estella’s two previous pregnancies had both resulted in miscarriages. She lived with her husband and his family.

Estella wanted to deliver in a health facility as she had not given birth before and she felt the facility would be better equipped to help with any complications. However, while Estella knew the advantages of giving birth at a health facility and had heard about health facility delivery on Our Tukul, she still delivered her baby at home.

“During the labour pain, I suggested I should be taken to the health facility to give birth. But people at home opposed me, saying that a health facility delivery will have a lot of difficulties.”

Estella’s experience demonstrates the importance of having a supportive family environment. Despite not being able to give birth in hospital, she did feel better prepared as a result of listening to Our Tukul because she had a birthing kit ready.

3.4.3 Essential newborn care

The first two days following delivery are critical for monitoring complications in mothers and newborns. Simple steps such as wiping and wrapping babies immediately after birth, putting them on their mother’s bare skin to keep them warm and refraining from bathing for at least 24 hours are highly effective measures that can dramatically reduce the risk of hypothermia. Despite the simplicity of these practices, many babies miss out on this care because mothers and birth attendants are unaware of them or do not understand the correct way to practise them.

*Case study from the 2014–2015 longitudinal qualitative study conducted in Kerepi. ‘Estella’ is not the participant’s real name.
In South Sudan, there are often mixed messages about correct essential newborn practice – with community members, key influencers such as husbands or mothers, and health professionals sometimes giving contrary advice. For example, formative research for this project suggested that there was mixed advice on what to do with the umbilical cord: some health practitioners suggested bathing it in salt water, and others suggested applying antiseptic, using ash if nothing else was available, or even doing nothing to the cord. Similarly, there were various cultural practices around washing a baby after birth, with some communities believing that they are born dirty.

The project aimed to shift some of these unhelpful beliefs and support the uptake of essential newborn care practices among women in South Sudan, specifically:

- Using clean instruments to cut the cord
- Thermal care of newborns, including delayed bathing

**Knowledge of essential newborn care**

All respondents were asked what they knew about how to keep a baby safe in the first 24 hours of life. On balance, responses outlining safer practices considerably outnumbered unsafe practices. Almost two-thirds of respondents suggested wiping the baby immediately (63%), while more than half suggested wrapping the baby in a clean cloth (53%). Two-fifths mentioned using a sterilised or boiled instrument to cut the cord (42%) and one-third mentioned immediate breastfeeding (32%). In total, approximately 45% of respondents correctly identified three or more neonatal care practices.
However, respondents also mentioned a number of potentially harmful practices. Around one-quarter believed babies should be washed immediately after birth (25%), and one in 12 (8%) thought newborns should be given honey, sugar solution, cow’s milk or other liquids before starting breastfeeding. The same proportion thought that dirt, mud, ash or oil should be applied to the cord stump (8%).

The results were similar among listeners, although more mentioned wrapping the baby with a clean cloth (65%) compared with non-listeners (52%). Qualitative research indicated that low knowledge around essential newborn care may be due to mixed messages about correct practices, both within the community and among health professionals in South Sudan. Further quantitative figures on audience members’ reported learning on essential newborn care are not available as questions on other key health behaviours were prioritised in the tracker survey.

3.4.4 Breastfeeding
Initiating breastfeeding within the first hour of birth and practising exclusive breastfeeding for the first six months is highly recommended as it has important benefits for both mother and child. For mothers, early breastfeeding stimulates breast milk production and releases a hormone that helps to contract the uterus and minimise blood loss. For newborns, having the first breast milk helps to protect against disease as it contains antibodies.

Formative research indicated that many misconceptions exist around breastfeeding and a limited understanding of what it means to exclusively breastfeed in South Sudan. Many women believed that colostrum is dirty and should not be given to a newborn. While most women were aware that breastfeeding is good for babies, they also believed that water and cow’s milk should be introduced immediately after birth because there is insufficient breast milk. Furthermore, if breast milk did not come immediately, many women believed it was suitable to give the baby sugar and salt with water instead. The formative research also highlighted a low understanding of the need for babies to suckle to start milk production.

BBC Media Action’s radio programming aimed to help increase adoption of the following essential newborn care behaviours among mothers in South Sudan:

- Breastfeeding newborns colostrum within one hour of birth
- Exclusively breastfeeding babies for the first six months of life

Throughout the duration of the Global Grant, Our Tukul continued to address misunderstandings and cultural beliefs and practices around colostrum and breastfeeding. Episodes in 2016 focused on the importance of colostrum, breastfeeding in the first hour after birth, and exclusive breastfeeding with the message “breast milk is enough”.

“The most important [thing learned from the programme] is after giving birth, you should breastfeed the baby for six months without giving them food or water – only the mother’s milk.”

Pregnant woman, Maban, vulnerable populations study, 2016

14 Chi-square tests were used to test for significance. All differences reported as significant were significant at the 95% level (p<0.05).
Relatively high knowledge of when to breastfeed

Findings from the 2016 survey indicated that overall levels of knowledge around breastfeeding were relatively high in South Sudan – nearly two-thirds of respondents (64%) reported that this should be done in the first hour after birth.

Furthermore, listeners to Our Tukul felt that the programme positively contributed to their knowledge around breastfeeding. Overall, 68% of listeners felt that they had learned something from Our Tukul about feeding their baby immediately after birth, including:

- Start breastfeeding within one hour of delivery/as soon as possible (79%)
- Give the baby colostrum (52%)
- Feed the newborn only breast milk for the first six months (44%)

The qualitative research showed that there were still some misunderstandings about exclusive breastfeeding among listeners. While some women claimed that they were exclusively breastfeeding, when probed it became clear that they were continuing to feed their babies liquids and foods.

19-year-old Viola Nancy speaks to Our Tukul producers about the benefits of exclusive breastfeeding
In August 2014, Grace was a 25-year-old housewife and was seven months pregnant. She lived with her husband and her first child, an 18-month-old son.

Grace had received some primary education. There was no radio in her house but she could listen to the programme as part of the listening groups set up during the longitudinal qualitative study, which she attended regularly.

Before she had her second baby and before she listened to Our Tukul, Grace spoke of colostrum as a bad thing. She believed that it was dirty and needed to be drawn out (but not fed to a child). When asked what other women did with the colostrum, she did not know but thought they did not feed it to their babies: “No they don’t give it, I have not seen. It did not happen in front of me.”

By the end of the project, Grace’s knowledge on colostrum had improved, which she attributed to Our Tukul.

“[Colostrum] is rich in vitamins and given to the baby immediately after delivering... [It is] for children to suckle but it is heavy and rich in vitamins... I heard it from Our Tukul.”

Grace also reported changing the way she breastfed her baby as a result of listening to the Our Tukul programmes. Previously, Grace thought that providing other foods within the first six months could be advantageous for a child. However, she subsequently changed her behaviour as a result of the programme.

“I used to [start supplementary feeding] at four months but the Our Tukul programme said [not to start feeding] water, porridge and soup until six months of age.”

By the end of the project, Grace’s knowledge on colostrum had improved, which she attributed to Our Tukul.

* Case study from the 2014–2015 longitudinal qualitative study conducted in Kerepi. ‘Grace’ is not the participant’s real name.

### 3.4.5 Other key health behaviours

In addition to the behaviours described above, Our Tukul and season one of Life in Lulu also included stories focusing on other key RMNCH behaviours including postnatal care, sexually transmitted diseases, family planning and vaccinations. In response to the outbreak of conflict in December 2013, the programmes responded to the emerging safety and health needs of the population, including landmine awareness, cholera and treatment of wounds.

No evaluative data was collected on these ad hoc behaviours. However, user testing research showed the potential of covering these topics. For example, members of some communities mentioned wanting to follow up and practise what they had learned after listening to an episode on handwashing and household cleanliness.
3.5 Impact on the media sector

Key insights

- Overall, this project’s capacity-strengthening work with local radio partners resulted in positive gains for these radio stations, though the extent to which they had implemented change was mixed.
  - Some trainees reported improvements in their skills and knowledge, including expanding the range and type of outputs they produced, interviewing skills and raising editorial standards by gathering multiple perspectives on stories and fact-checking sources.
  - Station managers reported increased levels of confidence in organising editorial meetings after receiving training. However, there was evidence that not all staff members were using editorial guidelines, and that editorial meetings were not happening regularly at all partner radio stations.
  - The radio stations reported that they were engaging with their listeners more. Similarly, audiences also felt more attracted to some new radio programming because of its relevance to them, although some highlighted the limited skills of some presenters.

At the outset of the project, the under-development of South Sudan’s media sector and lack of trained and professional journalists, and a low awareness of health issues within the media, were key issues identified as obstacles to improving health outcomes. The project sought to address these gaps by partnering with seven of the 16 local radio stations that broadcast the programme, to provide targeted capacity-strengthening, including technical and thematic training and mentoring (see appendix 1).

Throughout the project, needs assessments and research visits enabled BBC Media Action to refine its approach to provide the most appropriate support — including production, editorial and technical training. As outlined in section 1.2, capacity-strengthening activities were re-evaluated and redirected part way through the project, in 2014. The initial focus after that date was on building the capacity of the central production team in Juba before trying to build capacity at the local level. The broader capacity-strengthening activities were relaunched in April 2015. The objective of this was hoped to enable local radio stations to produce their own health content in local languages, to best engage and serve the needs of their local communities.15

The evaluation outlined below focused on three of the partner radio stations (Emmanuel Radio, Easter Radio and Don Bosco Radio) during the relaunched capacity-strengthening work in 2015.

The training took place in a challenging context, where conflict, limited options for revenue and wages, and an unsupportive environment for media resulted in weak management structures and near-constant staff turnover.

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15 Stations also received training around journalism from a number of organisations, including Journalists for Human Rights. As such, impact on specific outputs cannot be attributed solely to BBC Media Action, although attempts to isolate BBC Media Action’s support were made during research.
3.5.1 Improving the range of outputs and formats
One key aspect of the capacity strengthening was training to expand and improve the technical production skills among staff at the local radio stations. Participants reported that the training enabled them to improve the range and quality of outputs they produced, including PSAs, vox pops, pre-recorded news packages, discussion programmes and call-ins, as well as improved interviewing skills and the ability to cover a broader range of issues.

“The training] has helped because we didn’t have the knowledge for making programmes, but now we have been able to make our [own] programmes locally... We used to receive programmes produced in Juba and play them, but now we make our own programmes.”

Trained practitioner, capacity-strengthening assessment, 2016

Pride in these improvements was twinned with a desire to continue to improve. Some radio practitioners wanted more training on making magazine formats.

Some improvements were noticed by audiences too.

“When Radio Easter was established, they played only music and would open their lines so that people [could] call in to request songs. So many changes took place. Now, they have not only news but also sports news and some other programmes [on]... topics like ‘our community’.”

Radio Easter listener, male, capacity-strengthening assessment, 2016

However, some audience members pointed out weak presentation skills in some programmes (e.g. voices being too quiet to hear) showing the scope for further capacity strengthening, especially in a context of constant staff turnover and weak organisational structures at radio stations.

3.5.2 Raising editorial standards
A focus on raising editorial standards and supporting local radio stations to follow editorial guidelines was a core element of the capacity-strengthening work. Practitioners at three of the partner stations covered by the evaluation expressed confidence in using editorial guidelines as a result of this training. They talked about balancing stories, checking facts by confirming them with multiple sources, and discussing and deciding on stories during editorial meetings. However, this was not consistent among all staff trained, even within the same station. Across other non-trained staff, knowledge of editorial guidelines was piecemeal, suggesting that information-sharing within partner stations was weak.

Radio station managers expressed confidence in organising editorial meetings but in some of the evaluated stations no meetings were witnessed during the research. When questioned, some managers said that they were too busy with other management issues.
3.5.3 Audience engagement and responsive programming
Audience engagement and the use of audience feedback to inform programming is critical to producing relevant, engaging content and was a key element of this project’s capacity-strengthening work. Trained radio practitioners reported that they were interacting more with audience members to understand them better. Changes made as a result of this included altering the timing of some programmes to meet the needs of female listeners, and using listening groups to incorporate audience feedback into programmes. Partner stations’ programming also started to incorporate interactive elements to engage listeners.

Audience members also found partner stations’ programming relevant and some had noticed the content becoming more specific to community needs. Some audience members reported calling the programmes to share their views or ask questions, a finding echoed by journalist research participants.

3.5.4 Supporting organisational management and systems
Through the partnerships, BBC Media Action aimed to support station management to encourage “top-down” development by improving their organisations’ systems and processes. Areas of focus included formalising and improving financial management, and implementing staff development and human resources policies.

Some stations reported small changes in their financial strength. Station managers reported that the training had enabled them to develop small income-generation activities. However, this was not the case for all partners.
Some people may feel all their needs haven’t been met by the radio, they have high expectations. The radio should do this and that. The radio should continue for 24 hours… But the radio cannot continue for 24 hours with the limitations we have. This is what we tell them… and the audiences understand this.

Radio station director, capacity-strengthening assessment, 2016

There were mixed views about staff development policy across the stations. Managers reported having developed internal training plans, but not all staff members were aware of these plans and some felt that the training did not meet their needs. Where in place, human resources policies were not reported to have changed substantially. For example, some staff were not given contracts for a long time, leaving them feeling insecure about their futures.

**Sustaining good-quality health programming**

The overall aim of the capacity-strengthening element of the project was to support local partner radio stations to produce their own, good-quality health programming, even without the support of BBC Media Action. At the beginning of 2017, five local partners were producing such programmes without support.

However, the extent to which this will be sustained was unclear. South Sudan is facing a humanitarian crisis – conflict has caused some stations to go off air, and a lack of resources or the ability to generate revenue has affected staff retention.

Mother of three tells *Our Tukul* producer how she is monitoring the growth and weight of her children
4. Conclusion: to what extent did the project meet its objectives?

At the end of BBC Media Action’s five-year Global Grant-funded health project in South Sudan, has the uptake of key RMNCH behaviours increased among target populations? And are media practitioners better able to produce good-quality RMNCH programming that meets the needs of local audiences?

Given the challenging environment, including the limited supply of and access to quality healthcare for many South Sudanese people and the ongoing humanitarian crisis in the country, the extent to which the project was able to contribute to improved health outcomes was limited. The slow and disrupted development of South Sudan is reflected in recent estimates that indicate little has changed for its women and children in terms of maternal and child health outcomes. In 2015, South Sudan ranked 159 out of 179 countries for maternal and child well-being indicators in Save the Children’s State of the World’s Mothers Report.xxxii

The learning reported by Our Tukul listeners reflected the focus of the content of the programme, suggesting that the programming played a role in improving their health knowledge and reinforcing their existing knowledge. Listeners also reported some changes to health practices as a result of what they had heard – especially to home-based behaviour, such as taking more rest during pregnancy or adopting healthier breastfeeding habits.

Bringing about health-related social and behavioural change in South Sudan requires a combination of improvements in knowledge, shifts in social norms and increased confidence to seek appropriate healthcare. However, these improvements must be underpinned by the improved availability of healthcare resources and services.

Behaviour such as attending antenatal care, giving birth in health facilities, and family planning, fundamentally relies on people having access to trustworthy, good-quality healthcare services. Behaviour such as eating a diverse and nutritious diet relies on the availability and affordability of food, and practices such as avoiding hard work during pregnancy are subject to norms that take time to shift. Other behaviour, such as early and exclusive breastfeeding, depends more on being socially sanctioned and supported rather than the availability of resources.

In the context of limited health services, this latter type of behaviour is what this project most successfully managed to address. The realities of displacement, household financial constraints, food scarcity and intermittent healthcare service provision are insurmountable for many people in South Sudan, and there is still much more work to be done to save the lives of women and children living in the world’s newest country.
## 5. APPENDICES

### I. List of broadcast and capacity-strengthening partner radio stations

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<thead>
<tr>
<th>Broadcast partner</th>
<th>Capacity-strengthening partners</th>
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<tr>
<td>Radio Jonglei – Bor</td>
<td>Trained</td>
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<tr>
<td>Maridi FM – Maridi</td>
<td>Bakhita Radio – Juba</td>
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<tr>
<td>Mayardit FM – Turalei</td>
<td>Easter Radio – Yei</td>
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<tr>
<td>Radio Miraya – Bor</td>
<td>Trained and producing local language programmes</td>
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<td>Nhomlau FM – Malualkon</td>
<td>Anisa Radio – Yambio</td>
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<tr>
<td>Rumbek FM – Rumbek</td>
<td>Don Bosco Radio – Tonj</td>
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<tr>
<td>Voice of Eastern Equatoria – Torit</td>
<td>Emmanuel Radio – Torit</td>
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<td>Voice of Freedom – Magwi</td>
<td>Good News Radio – Rumbek</td>
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<td>Wau Radio – Wau</td>
<td>Voice of Hope – Wau</td>
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<td><strong>Catholic Radio Network</strong></td>
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<td>Anisa Radio – Yambio</td>
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<td>Bakhita Radio – Juba</td>
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<td>Good News Radio – Rumbek</td>
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<td>Voice of Hope – Wau</td>
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Appendix 2: Updated theory of change (2013)

THE CONTEXT

Priority health behaviours to be addressed:

• An estimated 17% of women attend all four antenatal care visits
• 81% of women still deliver at home
• Roughly 17% of women had skilled assistance at delivery
• Roughly 3% of children under the age of two had all recommended vaccinations
• 96% of women of reproductive age do not use any modern contraceptive methods
• There is a lack of essential newborn care practices
• About 45% of children are exclusively breastfed

The urban-rural divide:

• Health services are not uniformly spread; urban populations have more access than rural populations
• Findings from the 2010 South Sudan Household Health Survey indicate higher levels of healthy behaviour among urban and more educated populations
• While RMNCH needs are greater in rural areas, the needs are still substantial in urban and peri-urban areas

Media and communication landscape:

• Linguistic diversity of over 60 languages is a challenge to rational programming
• Simple Arabic is the most widely spoken language but most deep rural populations only understand their local languages
• While radio can reach a large population, face-to-face discussions are also crucial to effective communication, particularly in areas with limited access to radio

Target audience:

Women of childbearing age, husbands and older female family members

Objective 1

To use mass media communication in appropriate languages to shape knowledge, attitudes, norms, self-efficacy and societal support for change around key RMNCH issues.

Activities:

• Weekly radio magazine programme and radio drama in Simple Arabic
• PSAs in local languages on behaviour adapted for limited and no resource settings
• Short format, local-language programming by partner radio stations
• Capacity-strengthening of eight partner radio stations to contribute to weekly magazine programme and produce short format local-language programmes

Assumptions:

• Evidence-based assumptions about the effectiveness of particular radio formats
• Research-supported assumptions about the effectiveness of programming in local languages

Cumulative outcomes:

• Increased knowledge on key RMNCH issues, shifts in societal norms and increased social support among target populations
• Increased programming on RMNCH issues that caters to audiences’ language and information needs
• Increased opportunities for interpersonal discussion in rural and media-dark communities
• Increased capacity of media and health officers in seven states to communicate effectively on RMNCH in local languages
• Increased networking opportunities between media and health workers through outreach work

Contextual issues:

• The long-term benefits of capacity-strengthening may not be captured within this project
• Attributing behaviour change solely to BBC Media Action activities is a challenge
• Slow improvements in health service delivery
• Monitoring and evaluation is limited by the security situation

Objective 2

To use interpersonal communication (IPC) in appropriate languages to shape knowledge, attitudes, norms, self-efficacy and societal support for change around key RMNCH issues.

Activities:

• Develop an IPC toolkit to be used in listening group activities in rural and media-dark locations.
• Capacity-strengthening of media, government health promoters and NGO outreach officers to facilitate outreach activities

Assumptions: Research-based assumptions about the effectiveness of IPC to reinforce mass media

Population:

• Improved knowledge on key RMNCH behaviours among urban and rural audiences
• Increased uptake of healthier behaviours, including behaviours more dependent on health facilities among urban and peri-urban populations where facilities are currently available

Practitioner: Increased social and behaviour change communication (SBCC) skills among media professionals and government health promoters

Organisation: Increased collaboration between media, government and service providers on RMNCH communication activities

Systems and the enabling environment: Improved accountability through increased public engagement with health service providers and policy-makers
ENDNOTES


3 The Global Grant was a centrally managed grant from DFID that supported implementation of the Global Grant project in 14 target countries across Africa, Asia and the Middle East from 2012 to 2017. The five-year grant focused on three core themes (governance, health and resilience) and aimed to produce media and communication outputs that contribute to better governance, healthier populations and an increased ability to cope with humanitarian crises.

4 Lulu is a fictional town.

5 See appendix I for the full list of broadcast partners.

6 A simplified version of pidgin Arabic, the most widely understood language among the 60 languages spoken across South Sudan.


This Reporters without Borders ranking is based on several factors including: media pluralism, independence, legislative framework and transparency. Further information can be found here: https://rsf.org/en/detailed-methodology.


In November 2015, the South Sudanese parliament ratified a decree issue by South Sudan’s President Salva Kiir establishing 28 states in place of the 10 previously established states.

The local-language programmes included Radio Don Bosco (based in Tonj), Radio Emmanuel (based in Torit) and Radio Anisa (based in Yambio).

The Health Pooled Fund is a three-and-a-half-year partnership with the government of South Sudan’s Ministry of Health that aims to strengthen health systems and deliver essential health services across six states in South Sudan.

Formative research indicated that social norms – such as pregnancy being a process that requires no medical intervention – prevented the uptake of appropriate antenatal care and delivery.


The Health Pooled Fund is a three-and-a-half-year partnership with the government of South Sudan’s Ministry of Health that aims to strengthen health systems and deliver essential health services across six states in South Sudan.


More detail on BBC Media Action’s approach to evaluating capacity-strengthening interventions can be found in Parkyn, R. and Whitehead, S. (2016) Media Development: An Evaluation of five Capacity-