

The Republic of South Sudan
Ministry of Health



Reproductive Health Policy

**Present and Future Prosperity Through Safe
Motherhood and Healthy Childhood**

February 2013

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Abbreviations and Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante Natal Care
ASRH	-	Adolescent Sexual and Reproductive Health
BEmONC	-	Basic Emergency Obstetric and Neonatal care
BPHS	-	Basic Package of Health Services
CAs	-	Clinical Associates
CBO	-	Community Based Organisation
CEmONC	-	Comprehensive Obstetric and Neonatal care
CH	-	County Hospital
CHD	-	County Health Department
CHW	-	Community Health Worker
CMW	-	Community Midwife
CO	-	Clinical Officer
CPAC	-	Comprehensive Post Abortion Care
DCPH	-	Directorate of Community and Public Health
DG	-	Director General
DMS	-	Directorate for Medical services
DP	-	Directorate of Pharmaceuticals
DTPD	-	Directorate Training and Professional Development
EmONC	-	Emergency Obstetric and Neonatal Care
FBO	-	Faith Based Organisation
FGM	-	Female Genital Mutilation
FP	-	Family Planning
GBV	-	Gender-Based Violence
GRSS	-	Government of the Republic of South Sudan
HIV	-	Human Immune Deficiency Virus
HMIS	-	Health Management Information System
HSDP	-	Health Sector Development Plan
ICPD	-	International Conference on Population and Development
ICT	-	Information and Communication Technology
IEC	-	Information, Education and Communication
M&E	-	Monitoring and Evaluation
MDGs	-	Millennium Development Goals

MICS	-	Multiple Indicators Cluster Survey
MMR	-	Maternal Mortality Rate
MO	-	Medical Officer
MOH	-	Ministry Of Health
MVA	-	Manual Vacuum Aspiration
NGO	-	Non-Governmental Organisation
PHC	-	Primary Health Care
PHCC	-	Primary Health Care Centre
PHCU	-	Primary Health Care Unit
PMTCT	-	Prevention of Mother to Child Transmission
PPH	-	Post-Partum Haemorrhage
PwDs	-	Persons with Disabilities
RH	-	Reproductive Health
RHCF	-	Reproductive Health Coordination Forum
RHCS	-	Reproductive Health Commodity Security
RVF	-	Recto- Vaginal Fistula
SHHS	-	Sudan Household Health Survey
SMOH	-	State Ministry of Health
SOP	-	Standard Operating procedure
SSCCSE	-	Southern Sudan Centre for Census, Statistics & Evaluation
STIs	-	Sexually Transmitted Infections
TBA	-	Traditional Birth Attendant
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children’s Fund
VCT	-	Voluntary Counselling and Testing
VVF	-	Vesico-Vaginal Fistula
WHO	-	World Health Organization

Foreword

Due to the very high maternal mortality disease burden in the South Sudan, the Government of the Republic of South Sudan is committed to providing comprehensive and integrated Sexual and Reproductive Health (SRH) services in line with the recommendations of the 1994 International Conference on Population and Development (ICPD). The ICPD underscores the need for countries to meet the reproductive health needs of individuals and couples, throughout their lives, as a key approach to improving quality of life and stabilising the each country's population. The Republic of South Sudan also recognises the African Union Maputo Plan of Action, which advocates for integrated Sexual and Reproductive Health and Rights (SRHR). Since the signing of the Comprehensive Peace Agreement in 2005, the Ministry of Health, through the Department of Reproductive Health, has been establishing systems and mechanisms for coordinating the integration, implementation, monitoring, and evaluation of SRH services in the country. The Department of Reproductive Health is mandated to ensure effective coordination of the country's SRH programmes and service provision at all levels.

The Ministry of Health has developed this Reproductive Health Policy to provide the appropriate framework and guidance for the promotion and implementation of reproductive health programmes and interventions in the country. The ultimate aim of this policy is to provide an effective national platform for strengthening reproductive health interventions in South Sudan and facilitating the achievement of relevant global, regional and national goals in the interest of improved health, well-being and overall quality of lives of all peoples in the country. This policy is therefore a further demonstration of South Sudan's commitment to the achievement of the ICPD goals and targets within her national boundaries.

The policy has been developed through a highly consultative process involving various groups of stakeholders at various levels, and thus represents the aspirations of the people and government of the Republic of South Sudan to achieve an improved reproductive health status. This Policy is in line with South Sudan's national commitments and development goals as enunciated in the

South Sudan Development Plan 2011-2013 and the Health Sector Development Plan (2012-2016).

As we move forward, we sincerely encourage all South Sudanese, Non-Governmental Organisations, and development partners to actively support the implementation of this policy and ensure that the national reproductive health goals are achieved.

A handwritten signature in blue ink, consisting of a series of vertical strokes on the left and a large, sweeping loop on the right, followed by a horizontal line extending to the right.

Hon. Dr. Michael Milly Hussein
Minister of Health

Acknowledgements

The Ministry of Health extends sincere gratitude and appreciation to all who contributed to the development and review of this first Reproductive Health Policy for the Republic of South Sudan. Special thanks and recognition go to the Reproductive Health Department in the Ministry of Health for facilitating the process.

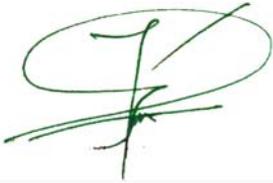
The Ministry would also like to thank the UNFPA for providing funding and technical resources for the development, review, editing printing and dissemination of this Policy; and recognises the financial support from the Swedish Government through Swedish Development Cooperation towards the finalisation, production, dissemination and rolling out the orientation of providers and other health sector stakeholders on the Policy across all the ten states of the country.

The following individuals and organisations are recognised for having, in one way or another contributed to the development of this Policy: Dr Alexander Dimiti of the Ministry of Health, Kondwani Mwangulube of the UNFPA for coordinating and leading the process at the various stages of the development of the Policy; Dia Timmermans, the consultant who facilitated the review and development process; Solomon Orero - JHPIEGO; Dr John Rumunu of the MSH and from UNFPA South Sudan Office: Simon Dada, Mary Marle, Gillian Garnett, Ulrika Rehnstrom, Silje Heitmann, and Joy Theophilus.

It is noted that this Policy evolved over time and the Ministry acknowledges the support provided by Dragudi Buwa and Magda Armah, formerly of the UNFPA for facilitating these initial processes. We also acknowledge the valuable comments and contributions from the following individuals during the various stages of the policy development: Jay Bagaria of DfID; Catherine McKaigof JHPIEGO; Edward Luka and Juliana Bol of MSH; Solomon Marsden of FHI360; Moses Ongom and Fikru Zeleke of the WHO; Martha Caydan of the UNICEF, Joy Mukaire of CHASS, and all the Reproductive Health Coordination Forum members. Contributions from the following MOH staff are also

acknowledged: Margaret Itto; Olivia Lomoro; Samson Baba; Lul Riek; Richard Lako; Janet Michael; Remo James and all Senior Management Team members.

We are also grateful to Colette Ajwan'g Aloo-Obunga for her role in editing and finalising the Policy.

A handwritten signature in green ink, consisting of a large, stylized 'M' and 'K' intertwined, with a horizontal line crossing through the middle.

Dr. Makur Matur Kariom

Undersecretary,
Ministry of Health

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive healthcare is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”- ICPD Programme of Action, Paragraph 7.2

1. INTRODUCTION

1.1. Preamble

This National Reproductive Health (RH) Policy aims to guide planning, implementation, standardisation, monitoring and evaluation of RH programmes and services in government, non-governmental organisations (NGOs), faith-based organisations (FBOs), community based organisations (CBOs), the private for-profit sector, public-private partnerships, and communities in South Sudan. The Policy is in line with the provisions of the South Sudan Development Plan, the National Health Policy, and the Health Sector Development Plan (HSDP) 2012-2015. It is to be seen as an updated version of the Maternal, Neonatal and Reproductive Health Policy (2007).

The overall goal of the Policy is attainment of enhanced reproductive health status for all individuals in South Sudan through increasing equitable access to comprehensive reproductive health services and improving quality, efficiency and effectiveness of services provided at all levels. The Policy also provides a framework for the review and revision of the National RH Strategy to effectively address the RH challenges faced by the country.

The health sector has a crucial role to play in the prevention and management of reproductive health problems. However, in line with the National Health Policy (NHP), this RH policy recognises that implementation of the full range of RH components requires a multi-sectoral approach and collaboration, a functioning health system, and strong partnerships that are accountable to both government and citizens, and which contribute to and follow the agreed upon national norms and standards. Therefore, fostering good partnerships, especially among the development partners, key line ministries, communities, CBOs, NGOs, FBOs and the private sector, will be essential for the policy's effective implementation.

This Policy respects human rights and freedoms, regardless of religion, culture and socio-economic status and further recognises the specific role women play in society and therefore the need to empower girls and women to protect and claim

their RH rights. Service providers in both public and non-public sectors are, therefore, called upon to respect patients' sexual and reproductive health rights in the provision of information and services and recognise that:

- *RH rights* are applicable to all couples and individuals, who have the basic right to decide freely and responsibly the timing, number and spacing of their children, to have access to information and education in order to ensure they make these choices from an informed position.
- *Sexual rights* enable all people to decide freely and responsibly on all aspects of their sexuality, and that they have the right to be free from conditions that interfere with sexual health such as harmful practices; sexually acquired conditions including STIs/HIV/AIDS; complications associated with menopause and andropause; coercion into having sex, and other forms of sexual violence.

Reproductive health services are essential for all people, married and unmarried, including adolescents and youth. For people to realise their reproductive rights, the ICPD Programme of Action (Para 7.6) calls for and defines reproductive and sexual health care in the context of primary healthcare to include:

- a) Antenatal care, safe delivery and post-natal care;
- b) Family planning;
- c) Prevention and appropriate treatment of infertility;
- d) Prevention of abortion and management of the consequences of unsafe abortion;
- e) Treatment of reproductive tract infections;
- f) Prevention, care and treatment of STIs and HIV/AIDS;
- g) Information, education and counselling, as appropriate, on human sexuality and reproductive health;

- h) Prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM;
- i) Appropriate referrals for further diagnosis and management of the above.

1.2. Background

For the majority of the population in South Sudan, access to healthcare, particularly reproductive health services, has been denied or severely hindered because of war. In most cases these services have either been absent or insufficient – a situation that has contributed immensely to the appalling reproductive health statistics in the country. It is in recognition of this that the Government of the Republic of South Sudan (GRSS) has, within the framework of the Comprehensive Peace Agreement (2005) and the National Health Policy 2007, envisaged a reproductive health package, which is comprehensive, PHC-integrative, situation-specific, sustainable, and equitable to address the root causes of the poor RH situation in South Sudan. The commitment of the government is reflected in the South Sudan Development Plan (2011-2013) and the Health Sector Development Plan (2012-2015) that seeks “*to ensure equitable, sector wide, accelerated and expanded quality healthcare for all the people in South Sudan, especially women and children*”. This policy, therefore, seeks to translate the vision of the government into a concrete framework with key strategies to positively transform the RH status of all the people of South Sudan. The development of this document is also a clear manifestation of the commitment of the government to advance the sexual and reproductive health and rights of its citizens as enshrined in the Maputo Plan of Action (2006)¹.

¹ Maputo Plan of Action 2006 : http://www.unfpa.org/africa/newdocs/maputo_eng.pdf

2. SITUATION ANALYSIS

2.1. South Sudan in Context

The population of South Sudan was 8,764.000 in 2010, (SSCSE 2010)², and was estimated at 10 million in 2011, and more than 12 million by 2015. This is due to the high rate of natural population growth (3% per annum), the high fertility rate (7.1 per woman) and the return of refugees and internally displaced people (IDP).

Reproductive health (including maternal, neonatal and child health) in South Sudan is set against complex political, demographic, economic, socio-cultural and technological contexts. South Sudan has experienced periods of intermittent wars and conflicts for over half a century. The longest civil war was twenty-two years (1983 to 2005). Fortunately, the Comprehensive Peace Agreement signed on 9th January 2005 in Nairobi, Kenya gave and continues to give South Sudan hope and an enabling environment for development. Despite this relatively peaceful atmosphere, some states in the country still experience pockets of inter-ethnic conflicts.

The country's National Baseline Household Survey (NBHS) conducted in 2009 showed that poverty in South Sudan is widespread with approximately half of the population (50.6%) living on less than the official poverty line³. This poverty is distributed in very definite spatial patterns:

- The poverty head-count rate in rural areas (at55.4%) is double the ratio in urban areas which is24.4%
- Poverty rates vary significantly between states; from three in four people in Northern Bahr al Ghazal state (75.6%) to only one in four people in Upper Nile state (25.7%)

² 8.3million 2008 census

³ The estimates established a poverty line of 73 SDG per person per month; at current exchange rates (July 2010); this translates to about \$1.04 per person per day.

South Sudan has a very young population. The NBHS documented that 72% of the population was under the age of 30, and 44.3% below the age of 15. In this context, it is unsurprising that the burden of poverty falls heavily on children: about half the population below the poverty line (49.2%) is below the age of 15. Disaggregation of the composition of the poor by sex reveals that the proportion of men and women among the poor is almost identical indicating that there is not a significant gender gap in poverty in South Sudan. Literacy rates are also very low in the country, with only 14.5%⁴ of women and 36.8% of men aged 15-49 years able to read and write.

Women's health is a major cause for concern in South Sudan. By the age of 19 one out of three girls is already married or in union; and the same proportion has already started childbearing. Contraception is utilised predominantly by urban and well-educated residents. The unmet need for spacing or limiting childbirth affects one in five women of child bearing age. Once pregnant, only a quarter of women receive antenatal care from a skilled provider and less than ten percent the recommended four antenatal visits. Barely one in ten has antenatal care that includes measurement of blood pressure, urine testing for proteinuria and blood testing for anaemia. A majority of women (87%) deliver their babies at home and nearly one quarter of women quote complications during labour and postpartum but more than 40% of these women will deliver unattended and only 15% of women will be attended by a skilled birth attendant. Less than 1% of women will receive lifesaving comprehensive obstetric care in the form of caesarean sections (0.5%); far less than the recommended five to fifteen percent needed to avoid the deaths of mothers and babies during obstructed labour. One in ten women receives vitamin 'A' supplement after giving birth, a simple inexpensive treatment that replenishes the mother and boosts the immunity of the breastfed child.

Based on the 2006 data⁵, the maternal mortality rate in South Sudan is 2,054 per 100,000 live births, arguably the highest in the world and translates into a one in seven chance of a woman in South Sudan dying during pregnancy or childbirth.

⁴2010 SSCSE MOH Summary findings of Household Survey

⁵ 2006 GOSS MOH and SSCSE Southern Sudan Household Health Survey

Although the maternal mortality rate could not be calculated from the more recent survey, the lack of progress in providing services, and particularly emergency obstetric care, suggest that the rate is unlikely to have improved.

Gender Based Violence is an accepted part of life in South Sudan. Eighty percent of men and women believe it is appropriate for men to beat their wives. Polygamy affects forty-one percent of women and also increases a woman's risk of sexually transmitted diseases, including HIV/AIDS. The risk of HIV infection among women in South Sudan is compounded by the fact that less than one in ten women has comprehensive knowledge about how to prevent transmission of the virus. Only fifteen percent of women know that HIV can be passed to the baby during pregnancy and childbirth. Less than one in ten women has been tested for HIV⁶.

South Sudan is multilingual, multi-ethnic and multicultural, consisting of more than sixty indigenous ethnic communities with diverse cultures. The working population are mostly subsistence farmers, pastoralists, fisher-folk and business people including petty traders. There are a number of cultural and traditional practices, which are inimical to health in general and maternal, child and adolescent health in particular. The low purchasing power of the people coupled with poor healthcare infrastructure has adversely affected healthcare delivery to the South Sudanese population in general and women and children in particular. The general economy of South Sudan is weak and largely dependent on donor in-flows and oil revenues. Infrastructure in information and communication technology (ICTs), electricity, water & sanitation, roads, transportation, buildings and equipment are very poor and thus serve as a hindrance to the development of a comprehensive healthcare programme.

2.2. Health System

The health system in South Sudan is organised broadly around four main pillars namely, the public, the NGO/FBO, the private and the traditional health systems.

⁶ idem

The NGO/FBO health system is sometimes classified as part of the private health system. RH services are currently delivered through each of these channels.

The health services are organised in a decentralised system. In the order of the lowest to the highest facility are the primary healthcare units⁷ (PHCUs), the healthcare centres (PHCCs), the county hospitals, the state hospitals and the teaching hospitals (formerly regional hospitals). There is a bias in the distribution of these services in favour of the urban areas. The private health system in South Sudan is yet to be fully developed. There are a few private clinics, most of them ill-equipped and largely unregulated.

The Directorate of Training and Professional Development in the Ministry of Health has categorised the Human Resources for Health cadres in 2011. Table 1 gives a summary (not exhaustive) number of cadres available in the health sector in 2011 with a focus on delivery of RH services.

Table 1 Human Resources for Health with RH focus

Category	Number	Remarks
Obstetricians/gynaecologists	12	Total # of specialists: 36
Anaesthesiologists	1	
Medical officers	368	
Clinical Officers/Medical Assistants	574	
Registered Midwives	19	3 years+ training
Certified Midwives	36	2 year training
Community Midwives	96	
Laboratory Technicians/Technologists	549	
Nurses	2797	18 months training
Pharmacists/Pharmacists Assistants	341	
Radiologists/Radiographers	28	
Community HW/MCHW	1894	

Source: Ministry of Health Policy Framework 2013

⁷ In line with new health care system the PHCU will be phased out

*Exact numbers not known

2.2.1. Health System Challenges

In general the health system in South Sudan faces several challenges including, but not limited to:

- Inadequate and inequitable distribution of human resources, both technical and administrative, at all levels (national, state, county and payam);
- Weak administrative systems at county and local levels;
- Inadequate financial and material resources;
- Dominance of individual NGOs and other international agencies in the control of the formal health system even though their primary mandate still remains humanitarian and emergency in nature;
- Weak health management and administrative support systems including system-wide planning, monitoring and evaluation;
- Absence of well-defined quality standards and benchmarks for the delivery of healthcare;
- Unequal distribution of health services with an urban bias; to the disadvantage of rural communities.
- Frequent shortages of drugs in public hospitals and pharmacies coupled with non-affordability of drugs from private pharmacies by the vast majority of the populace.

2.3. Reproductive Health Indicators

According to the South Sudan Household Health Surveys (SHHS 2006 and 2010), South Sudan has some of the worst reproductive health status indicators in the world. Table 2 below provides a summary of some key indicators from the two surveys as well as the targets set for 2015:

Indicators	2006	2010 ⁸	Target 2015
Maternal Mortality (per 100,000 live births)	2,054		1680
% Women with births overseen by skilled birth attendants in HFs	10.0	14.7 ⁹	20.0
Contraceptive Prevalence Rate (%)	3.5	4.5; 1.5 ¹⁰	7.0
Teenage pregnancies (15-19) (per 1000 in age group)	204	300	
% of women paying at least one antenatal visit with skilled birth attendant	26	30	52
% Women receiving 4 antenatal visits	10	9.3	
Unmet need for family planning (%)	1,2	24 ¹¹	

Table 2: Maternal health indicators and MDG5 a and b target indicators for 2015

2.4. RH Service Delivery

Service Delivery for reproductive health can be divided into the following categories: antenatal care, delivery care (including C-section), postnatal care, family planning services and VCT/PMTCT services. The state of these services is poor in the whole of South Sudan, with 86.9% of women delivering outside health facilities (2010¹²). The few state hospitals, which have registered midwives for normal delivery and specialists (obstetrician/gynaecologists, anaesthetists) for complicated cases, perform, apart from the normal delivery, mainly emergency surgical procedures such as caesarean section, sub-total hysterectomy, manual removal of the placenta, repair of genital injuries and uterine evacuation. Most facilities lack the human resources, the equipment and supplies, and therefore the capacity for basic and advanced obstetrics care. Broadly, there are very limited gynaecological and obstetric care services in South Sudan. Advanced gynaecological procedures and services such as pap smear examination; management of gynaecological tumours and repair of VVF/RVF among others are currently not routinely available. Even though

⁸ SSCCEC 2010 Summary findings of Household survey

⁹ Definition by GOSS MOH : verified skilled birth attendance

¹⁰ 4.5% all methods, 1.5% modern methods

¹¹ Unmet need for contraception refers to fecund women who are not using any method of contraception, but who wish to postpone the next birth or who wish to stop childbearing altogether. Unmet need is identified in MICS by using a set of questions eliciting current behaviours and preferences pertaining to contraceptive use, fecundity, and fertility preferences

¹² 2010 Summary of SS Household Survey

abortion is a major cause of maternal morbidity and mortality, post-abortion care (PAC) using manual vacuum aspiration, is only provided in a few hospitals.

3. POLICY FRAMEWORK AND PRINCIPLES

3.1. Mission Statement of the MOH

To provide equitable, sector wide, accelerated and expanded quality health care for all the people in South Sudan, especially women and children.

3.2. Policy Theme

Present and future prosperity through safe motherhood and healthy childhood

3.3. Policy Goal

To reduce maternal and neonatal morbidity and mortality and improve the reproductive health status of the people of South Sudan through the provision of a comprehensive, universally accessible, quality, integrated, equitable and sustainable comprehensive reproductive healthcare package¹³.

3.4. Policy Objectives

- To build the capacity at all levels of the MOH and partners to deliver quality comprehensive reproductive health services.
- To establish an equitable resource allocation framework for the RH sub-sector at all levels.
- To increase funding for RH programmes and services especially for the poor, vulnerable, disadvantaged and difficult to reach communities.
- To empower individuals, families and communities to claim and exercise the right to access RH services.

¹³ BPHS Key RH Interventions and Services in Annexe 2

- To promote an enabling legal and socio-cultural environment that ensures individuals, especially women and girls, are able to claim and exercise their rights.
- Promote evidence based interventions that will mitigate against the poor child health indicators.

3.5. Expected Outcomes

The expected RH Policy outcomes throughout South Sudan will include:

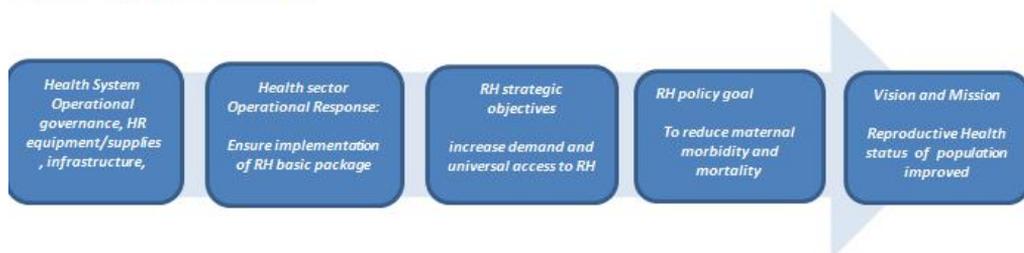
- Universal and equitable access to quality comprehensive RH services;
- Progressive decline in maternal and neonatal morbidity and mortality;
- The creation of an enabling environment in which adolescents can access information and services freely, and survivors of gender based violence are cared for appropriately.

3.6. Conceptual Framework

The conceptual framework underlying the development of the RH Policy is derived from the vision of the Ministry of Health in its National Health Policy for ‘...a healthy and productive population, fully exercising its human potential’ and from the theme for this RH policy: “*Present and future prosperity through safe motherhood and healthy childhood*”.

Figure 1:

RH Conceptual framework



This conceptual framework underpins the hypothesis that in protecting women's health, the women would, by themselves, be able to contribute to economic prosperity. Globally, and in Africa in particular, women have been recognised as major contributors to national economies in spite of their current marginalisation. Furthermore, healthy women would give birth to healthy children who will have a better chance of growing-up to become healthy adults capable of contributing to their societies' development, prosperity and leadership. It will therefore be worthwhile instituting the necessary health, social and legal interventions which guarantee and protect the health of mothers and children.

Arising from the MOH vision and the policy theme, the following principles guided the development of this Policy:

- 1. Human Rights:** This Policy respects human rights and freedoms, regardless of religion, culture and socio-economic status. Service providers in both public and non-public sectors should respect and foster the reproductive health and sexual health rights of individuals when providing information and services.
- 2. Community Participation:** Reproductive health services need to be responsive to expressed needs of the consumers. However, the policy also recognises that individuals and/or communities have both rights and responsibilities in promoting their own health and development.
- 3. Gender Sensitivity:** All service providers should understand that both men and women have important roles to play in RH and provision should be gender sensitive and to engage both men and women in RH issues
- 4. Equity:** Equitable access to RH services and in particular the reduction of financial, social, political, and cultural barriers to those seeking reproductive health information and services, especially among the more vulnerable members of the population that include, but are not limited to:

- Youth and adolescents, including single parents;
- The poor in urban, rural, and hard to reach areas;
- Persons with disabilities (PwDs)

5. Public Private Partnership: the Ministry of Health through the Directorate of Community and Public Health (DCPH) has stewardship of the national RH Policy and will work closely with its partners to ensure the implementation of the Policy.

3.7. Policy Imperatives

Five basic strategic policy imperatives will guide the provision of reproductive healthcare services in South Sudan. These are:

1. Ensuring universal access while targeting RH services at the most vulnerable, disadvantaged and minority segments of the population;
2. Ensuring equitable, cost-effective and cost-efficient public resources allocation to reduce disparities in reproductive health service delivery;
3. Enhancing regulation in all aspects of reproductive healthcare provision for quality assurance;
4. Creating an enabling environment for increased private sector, NGO and community involvement in RH service provision and financing;
5. Increasing and diversifying per capita financial flows to the RH sub-sector.
6. Promotion of evidence based interventions that will ensure and accelerate the reduction of maternal and child mortalities.

4. PRIORITY AREAS IN REPRODUCTIVE HEALTH

This Policy recognises the following priority areas for addressing the major reproductive health challenges facing South Sudan. They are in tune with the declaration of the Maputo Plan of Action (2006), which reiterates the civic obligation of African leaders to respond to the sexual and reproductive health needs and rights of their people. The key areas are two-fold: those that are service related (safe motherhood, service coverage and accountability, gynaecological care, GBV and RH rights, and RH needs of special groups); and those that are systemic and cross-cutting (infrastructure, human resources, financing and information systems).

4.1. Service related areas

4.2.1. Safe Motherhood

Key Issues:

- High maternal morbidity and mortality largely due to haemorrhage, retained placenta, obstructed labour, pre-eclampsia/eclampsia, abortion (these are the direct causes) and anaemia, poor nutrition, malaria, and poor state of health facilities for referrals and emergency response (these are the indirect causes);
- Limited number of facilities for managing obstetric and neonatal emergencies;
- High neonatal morbidity and mortality largely due to malaria, asphyxia, low birth weight, infections, anaemia, gastro-enteritis/dehydration and malnutrition;
- Inadequate access by women, men and adolescents to comprehensive RH information and to skilled care throughout the continuum of care for family planning, pregnancy, delivery, post-partum and post-natal periods.

- Inability to audit the health system, services and interventions.

Response

- Offer comprehensive and quality RH services aimed at significantly reducing maternal and neonatal morbidity and mortality to all those who require such services with a specific focus on difficult to reach members of the population.

4.2.2. RH Service Coverage and Accessibility

Key Issues:

- Minimal access to healthcare: estimated user rate as low as 0.2 contacts with a health professional per person per year; and more than two-thirds of the population not having access to formal health services.
- Unequal distribution of services: rural population estimated to be 80% under-served.
- Small size of health facility network: 52hospitals, 252PHC centres and 988 PHC units, many of these facilities are in a poor functional state.
- The majority of existing health facilities do not provide minimum package of RH services¹⁴

Response

Make quality comprehensive RH services available to all persons, irrespective of their location within South Sudan.

¹⁴ 2010 MOH Summary Health Facility Mapping

4.2.3. Gynaecological Care

Key Issues:

- Limited facilities for the diagnosis and management of gynaecological disorders;
- HIV/AIDS has the potential to become a significant problem in South Sudan with the influx of returnees from neighbouring countries where HIV/AIDS is prevalent;
- Nearly all health facilities in South Sudan lack the capacity to effectively investigate and manage fertility and reproductive tract cancers.

Response

Build capacity in teaching and state hospitals to effectively diagnose, manage and follow up gynaecological, medical and surgical conditions.

4.2.4. Gender-based Violence and Reproductive Health Rights

Key Issues:

- High prevalence of gender-based violence (GBV) and abuse including sexual violence, domestic violence, emotional and psychological abuse, early or forced marriages, prostitution, and sexual exploitation amongst others.
- Rape is still very common but hardly reported.
- Domestic violence in pregnancy is a significant cause of abortion and maternal morbidity and mortality.
- Female Genital Mutilation (FGM), though not a general problem in South Sudan, is common amongst peoples living in the Nuba Mountains with a prevalence of about 73% in some communities.

- Absence of effective legislation to address gender-based issues.
- Non-existence of an audit system of the health services delivery system and the services provided.

Response

Eradicate all forms of gender-based discrimination and violence and accord equal rights and dignity to citizens of both sexes throughout South Sudan.

4.2.5. RH Needs of Special Groups

Key Issues:

- There are several groups in South Sudan with special RH needs such as the military (SPLA), marginalised communities, people with disabilities, the youth and adolescents among others.
- Existence of particularly vulnerable groups and communities including returnees, pastoralists, internally displaced people (IDPs), PwDs and communities in hard-to-reach areas.
- There is no system, framework or programme to direct the response to the peculiar reproductive health needs and circumstances of these special groups.
- Relative neglect of youth and adolescent sexual and reproductive health and rights including early and forced marriages; sexual engagement and pregnancy in teenage girls; early exposure to HIV/AIDS and STIs; FGM; drug and substance abuse; unemployment among others.
- Weak health system for adequate response to the RH needs of the military forces.
- Organised forces ‘access to healthcare.

Response

Guarantee ready and easy access of the ‘neglected’ groups to quality comprehensive RH services and programmes and to ensure their optimum health.

4.2. Systems and Cross-cutting Areas

These are the areas necessary for attaining an enabling environment for undertaking effective RH programming and interventions, including service provision.

4.3.1. Development and Maintenance of Infrastructure to Support RH Service Delivery

Key Issues:

- Health facilities are few, unequally distributed and inadequately developed to support quality comprehensive RH service delivery.
- In rural areas, there are about 14,000 people per health unit, 75,000 per health centre and 400,000 per hospital¹⁵.
- Lack of basic obstetric care equipment in most health facilities.
- Lack of advanced gynaecological and obstetric services in all hospitals.

Response

Build and/or put in place an adequate number of well-equipped health facilities capable of offering appropriate (basic or advanced) RH services in all states.

4.3.2. Human Resource Development and Management

Key Issues:

¹⁵ The MOH Basic Package for Health Services refers to the Minimum set of RH services that persons seeking RH services expect to get as outlined in the BPHS. The Package further recommends: 1 PHCU for a population of 15,000, 1 PHCC for 50,000 people and a county hospital for 300,000.

- Inadequate human resources capacity in all aspects of healthcare delivery especially in the provision of RH services.
- Lack of capacity to implement immediate interim steps to: significantly reduce maternal and neonatal mortality (*Basic EmONC concept*); and ultimately achieve the optimum (*Comprehensive EmONC approach*).
- High turnover, low remuneration and disparity in geographical distribution of health care staff/providers.

Response

Achieve optimum human resource capacity, in terms of numbers and quality, necessary to render the requisite RH services efficiently and effectively at all levels of the healthcare delivery system in South Sudan.

Table 3: Proposed Professional Medical and Paramedical Staff Establishment in Facilities Necessary for Effective Delivery of RH Services

LEVEL OF FACILITY	CADRE OF STAFF AND NUMBERS REQUIRED									
	Obstetrician/ Gynaecologist	Medical Officers	Professional midwives	Health Visitors	Clinical Officer/Medical Assistant/ Clinical Associates	Enrolled Nurses/Professional Nurses	Pharmacist	Pharmaceutical Technologists	Pathologists	Laboratory Technologists
Teaching and referral hospitals	4	10	25	5	20	60	2	10	2	10
State hospitals	2	12	15	5	16	40	1	6	1	8
County Hospitals		4	7	3	12	20		4		6
PHCC			3	1	4	10		1		2

Source: Health Sector Development Plan, 2012-2016

4.3.3. Financing RH Service Delivery

Key Issues:

- Economy of South Sudan is in its incipient stage;
- Low purchasing power of the citizens of South Sudan;
- Huge gap between resources available and what is required;
- Possible effect of global economic recession on bilateral and multilateral donor in-flows to fund RH services;
- Weak management structures to deal with financial resource utilisation, accountability and reporting;

Response

Mobilise the financial resources required to provide comprehensive and quality RH services to all segments of the population; and to ensure the judicious, accountable and cost-effective use of such resources.

4.3.4 RH Information Systems

Key Issues

- Lack of modern, effective and efficient health management information systems and health information records at the ministerial, institutional and health facility levels.
- Dependence on archaic information management systems.
- Lack of reliable baseline health information.

- Non-existence of a common system for planning, monitoring and evaluation for central and state Ministries of Health.

Response

Integrate RH information into an improved national health management information system (HMIS).

4.3.5 Framework for Research in Reproductive Health

Key Issues:

- Lack of research capacity in RH practice in South Sudan
- Lack of comprehensive baseline information on RH issues and indicators
- Lack of EmONC baseline information for South Sudan

Response

Develop and promote research as a powerful tool for innovative and creative response to RH problems; and for the planning, development, and evaluation of policies and strategies.

4.3.6 Regulation of RH Service Delivery

Key Issues

- The government of South Sudan through the Ministry of Health has the primary responsibility for ensuring that those providing health services safeguard the public interest.
- Lack of health sector specific laws, regulations and institutional capacity to regulate and enforce good medical practice at all levels of the health system.

- The private sector is largely unregulated resulting in the provision of sub-standard services.

Response

Establish and implement an effective RH regulatory framework that will ensure the best professional and ethical healthcare practices are enacted. This will ensure quality service delivery and safeguard the public interest.

5. IMPLEMENTATION FRAMEWORK

This chapter defines the policy implementation structures, processes and mechanisms and outlines the framework for its financing, monitoring and evaluation.

5.1. Policy Implementation Approach

The Ministry of Health, within the framework of the South Sudan Development Plan (2011-2013) and the Ministry of Health Policy Framework and Work Plan (2013-2016), shall ultimately adopt the Sector/System Wide Approach (SWAp) for the implementation of the policy. The implementation strategy will emphasise the principles of aid and development effectiveness as laid down in the Paris Declaration (2005) and the Accra Agenda for Action¹⁶: ownership, alignment, harmonisation, results oriented management and mutual accountability¹⁷.

¹⁶http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00&&en-USS_01DBC.html

¹⁷*Ownership* - Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption

Alignment - Donor countries align behind these objectives and use local systems

Harmonization - Donor countries coordinate, simplify procedures and share information to avoid duplication

Results - Developing countries and donors shift focus to development results and results get measured

Mutual Accountability - Donors and partners are accountable for development results.

5.2. Development of RH Strategies

The Ministry of Health at both central and state levels will facilitate the development of a five-year RH Strategic Plan as an implementation instrument and a management tool of the RH Policy. The five-year RH Strategic Plan is expected to serve three purposes:

- (i) As the roadmap to attain the three expected outcomes stipulated in this Policy;
- (ii) Provide a framework for operational planning, resource mobilisation, monitoring and evaluation; and
- (iii) Provide guidance to the MOH, State Ministries of Health, County Health Departments and non-governmental stakeholders for the development of RH programmes at their respective levels. Annual operational plans will be developed guided by this roadmap and appropriate to the context of the RH challenges and unique experiences and needs at state and county levels.

5.3. Policy Implementation Structures

This Policy will be implemented within the MOH structural framework. Using the Basic Package of Health Services (BPHS) approach, the RH Policy will be realised at four levels as follows:

1. Community level (Community-based RH activities)
2. Healthcare centre (PHCC) level
3. County Hospital (CH) level
4. County Health Department (CHD) level and SMOH

The state and teaching hospitals in South Sudan are essential in the referral and service delivery chain. Services operated by the non-governmental sector will also follow the same classification depending on their level of resources and capacity.

5.4. Management and Co-ordination Framework: Roles and Responsibilities

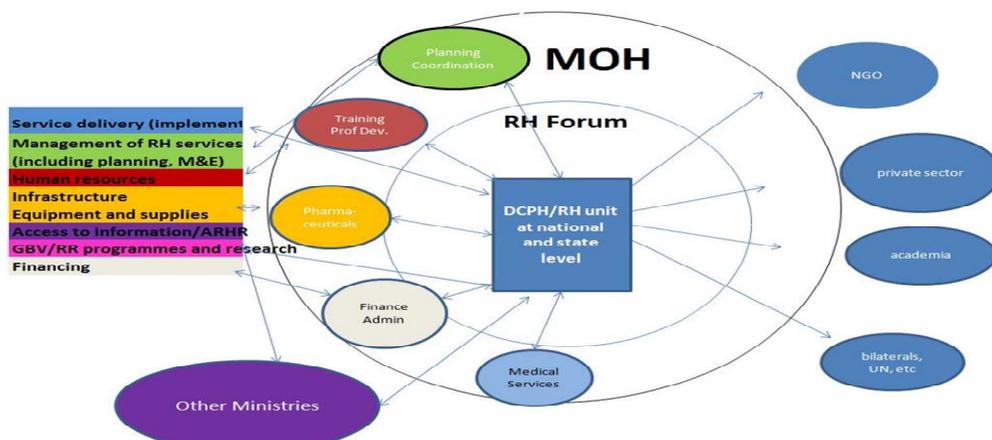
The overall health sector management and co-ordination framework stipulated in the National Health Policy will be used to guide the implementation of the RH Policy at all levels.

5.4.1. Role of the Ministry of Health at Various Levels

The Ministry of Health: the Ministry of Health shall ensure that the State Ministries of Health and County Health Departments have the requisite capacity in terms of staffing, equipment and supplies to effectively plan, supervise, monitor and evaluate the implementation of RH Policy at their respective levels. Specifically, the MOH through the Directorate of Reproductive Health shall:

- Oversee the development, implementation and monitoring and review of the Policies and the RH Strategic Plan;
- Set standards, technical guidance and regulatory mechanisms for quality assurance, capacity building and training activities;
- Coordinate the RH activities undertaken by non-governmental organisations and donors;
- Ensure adequate allocation of government and complementary external resources to RH programming and service provision;
- Undertake supervision, monitoring and evaluation of RH activities at state level.

Fig 2: Conceptual framework for coordination of Reproductive Health in South Sudan



Within the Ministry of Health all the directorates are expected to be involved in the implementation of this Policy as follows: the Directorate of Human Resource Management and Development will be responsible for the training and general human resources development for RH; the Directorate of Pharmaceuticals and Medical Supplies for RH Commodity Security; and the Directorate for Medical Services for facility-specific infrastructure development and/or expansion.

To facilitate a multi-sectoral involvement at the central level, the MOH shall establish and convene the Reproductive Health Coordination Forum (RHCF) as a mechanism to strengthen the coordination, alignment and harmonisation of all the RH programmes and interventions in South Sudan.

The State Ministry of Health: A Reproductive Health officer (RHO) will be nominated in the State Department of Health to coordinate and facilitate joint RH programme planning and implementation. The RHO shall also coordinate the supervision, monitoring and regulation of RH activities within the state. The RHO, in close collaboration with the Directorate of Reproductive Health shall promote RH training and capacity building within the state and convene the State RHCF to facilitate the coordination of all RH related activities by other actors (other ministries, NGOs and major development partners).

The County Health Department: At the county level, there shall be a county RH officer, who would be expected to guarantee the implementation of the RH Policy; liaise with other authorities and non-governmental RH service providers; supervise RH activities within the county; and train and support community-based RH workers.

5.4.1 Roles of Other Line Ministries at the Central and State Level

This Policy embraces a multi-sectoral approach, which includes linkages with key line ministries such as:

- *Ministry of Finance and Economic Planning:* for financial resource allocation and management, resource mobilisation, procurement and data/information management.
- *Ministry of General Education and Instruction:* for curriculum development and implementation; training and capacity building as well as for the inclusion of “Family Life Education” at all levels of the education system.
- *Ministry of Gender, Child and Social Welfare:* for social mobilisation, employment policies and gender empowerment.
- *Ministry of Information and Broadcasting:* for IEC of RH messages and communication.
- *Ministry of Housing and Physical Planning:* for the construction and maintenance of health facilities.
- *Ministry of Culture, Youth, and Sports:* for the development of adolescent and youth reproductive health and development policies and strategies; putting in place inter-ministerial coordination mechanisms for a multi-sectoral approach to adolescent and youth issues.

- Ministry of Defence and Veterans Affairs and Ministry of Interior: for security, enforcement of RH related laws (e.g. GBV) and ensuring participation of security organs in RH activities.
- Ministry of Roads and Bridges, and Ministry of Transport: for road network, river and air transport.
- Ministry of Agriculture and Forestry: for food security and nutrition necessary for promotion of reproductive, maternal, neonatal and child health.
- Ministry of Irrigation and Water Resources: for supply of potable water and sanitation.
- Ministry of Justice: for drafting of relevant legislations and awarding service contracts.
- Ministry of Foreign Affairs and International Cooperation: for international advocacy, fund sourcing/resource mobilisation and cooperation
- Ministry of Telecommunications and Postal Services: for telecommunications and promotion of future telemedicine.
- The Parliament: for the enactment of relevant laws/legislations, guiding formulation of policies and for advocacy to increase budgets for RH interventions.
- The Judiciary: for the enforcement of RH-related laws and rights and ensuring the administration of justice
- The Presidency: for high level political support for RH, national and international advocacy and public mobilisation for expanded RH programmes and services.

Through this Policy, the Ministry of Health seeks to encourage all these ministries and state institutions to mainstream RH issues in their core functions.

5.4.2 Role of NGOs, FBOs and the Private Sector

The NGOs play an important role in the RH service delivery and in capacity development in South Sudan. The government shall continue to foster partnership and continue to contract various NGOs, FBOs and private organisations to deliver RH services in targeted areas. The MOH also expects these organisations to complement government efforts beyond the contracted services and assist in leveraging financing, implementation, joint monitoring and evaluation of RH plans and programmes at various levels of RH programming and service delivery. The Ministry will strengthen its capacity to coordinate and harmonise the various RH interventions in the country, based on the agreed basic package for key RH services. Tools such as memoranda of understanding (MOUs) and codes of conduct will be used to facilitate coordination, alignment and harmonisation of RH interventions at central, state and county level.

5.4.4 Role of Professional and Regulatory Bodies

Organisations such as professional associations and regulatory bodies shall play a major role in the regulation and enforcement of this Policy. The professional bodies would be required to self-regulate their members to provide RH services to the highest professional and ethical standards.

5.4.5 Role of the South Sudan National Bureau of Statistics (NBS)

The South Sudan National Bureau of Statistics (NBS) will collaborate with the Directorate of Policy, Planning and Budgeting to undertake the monitoring and evaluation of the implementation of this RH Policy and the accompanying Strategy Document.

5.4.6 Role of Development Partners/Donors

Development partners, both bilateral and multilateral, are expected to provide financial and technical support towards the health sector in general and the provision of RH services more specifically, within the framework of policy,

priorities and strategies of the MOH. To this end, the development partners are requested to provide advisory services, technical assistance, international advocacy and capacity building services to support the implementation of the Policy. Tools such as memoranda of understanding and appropriate codes of conduct will be used to facilitate coordination, alignment and harmonisation in the context of the Sector Wide Approach, including reproductive health, at central, state and county level.

5.4.7 Role of the Community

Communities shall play a major role, both as beneficiaries and promoters of RH services. They are expected to play a key role in promoting the uptake of RH services, including referral for delivery in the PHCC. The community members are encouraged to use the RH services provided, and participate in the planning, implementation, monitoring and evaluation of RH interventions undertaken in their communities. To ensure effective and meaningful community participation in the policy implementation process, the communities should be mobilised and represented through existing community-based structures and organisations. The community is encouraged to initiate community-based health development initiatives and support the local health services (PHCCs) through community mobilization, health promotion and mortality surveillance.

5.4.8 Role of Training Institutions

Various training institutions (local, regional and international) including approved and accredited universities; nursing and midwifery schools; mid-level medical/health training institutions; and the private, public, NGO and faith based medical/health training hospitals shall play a major role in providing both formal and non-formal basic and continuous learning programmes. The training programmes should lead to academic and/or professional certification. They should also conform to international RH training standards, including guidelines and curricula.

5.4.9 Role of the Media

The media are expected to play a key role in advocating for community and stakeholder interventions; creating mass public awareness and knowledge about RH issues; promoting and/or sustaining positive and healthy behaviour change in relation to RH; and increasing public awareness and knowledge of the legal/human/gender rights associated with RH. The Ministry of Health, in this regard, shall develop a RH communication and media strategy for South Sudan, which will define the role of the media in RH, the framework, guiding principles and key elements of RH multi-media communication strategy.

5.4.10 Role of Health Facilities

All health care facilities have a role to play in the provision of RH services. The scope of RH services to be provided by a facility would depend on its designation, level of resources and capacity as referred to in the BPHS¹⁸

5.5 RH Financing Framework

To ensure a steady stream of funding to implement this Policy, the MOH shall formulate a *Five-Year RH Financing Plan* to accompany the RH Strategic Plan as part of the overall *Five-Year Health Sector Financing Plan*. The aim would be to increase public funding for health in general and more specifically to RH through preferential allocation of central government and state budgets to RH service delivery.

5.6 Financial Resources

The government of South Sudan is providing the bulk of financial resources for reproductive health, with the support of various bilateral and multilateral development partners, including UN agencies. NGOs, involved in health sector service delivery at state and county levels will continue to receive support from donors either directly or through the government mainly for contracted services.

¹⁸ Full list of levels and RH related activities in annex 4

5.7 Monitoring and Evaluation Framework

The Ministry of Health considers monitoring and evaluation (M&E) as critical aspects in the management and delivery of RH services. The Ministry, working closely with its partners and the South Sudan National Bureau of Statistics (NBS) shall, therefore, develop RH M&E frameworks and guidelines for continuous monitoring as well as for process and impact evaluation of RH interventions and services within the context of the overall M&E system under the Health Sector Development Plan.

The M&E system for this Policy will also be integrated into the HMIS of the MOH's Directorate of Policy, Planning and Budgeting, with a view to ensuring the collection of RH data to inform decision-making, planning and programme development processes.

5.8 Coordination

To ensure effective tracking of the RH Policy implementation process, the Ministry shall formalise the RH Coordination Forums at MOH and SMOH levels, whose scope of work and terms of reference will include, among other things¹⁹, planning and institutionalisation of technical reviews. The results of the reviews will then be discussed in the Joint Health Sector Annual Reviews.

¹⁹ At state level this may be called a sub-sector working group on RH as part of the overall health sector coordination group

Annex 1: Key references:

1. SSCCSE 2006 Household survey
2. SSCCSE 2008 The Sudan Population and Housing Census
3. SSCCSE 2009 Poverty in South Sudan, estimates from NBHS 2009
4. SSCCSE 2010 South Sudan MDG Report 2010
5. SSCCSE 2010 Summary findings of the 2010 Household survey
6. GOSS 2011 South Sudan Development Plan 2011-2013
7. MOH/UNFPA 2007 Situational Analysis of RH and ARH in South Sudan
8. GOSS/MOH Maternal Neonatal and Reproductive Health Policy 2009 - 2015
9. GOSS/MOH MNRH Strategy 2009-2015
10. GOSS MOH 2007 Strategic Plan for Human Resources 2007-2017
11. GOSS MOH Health facility Mapping 2010
12. HLSP review of BSF
13. UN ICPD Programme of Action 1994 : <http://www.un.org/popin/icpd2.htm>
14. Africa Union Commission: Maputo Plan of Action 2006:
http://www.unfpa.org/africa/newdocs/maputo_eng.pdf
15. UN Millennium Development Goals and Indicators (update 2008)
<http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>

Annex 2: Functions of the South Sudan MOH at different levels

Central level

- Leadership, governance, stewardship sector wide
- Regulation and legislation
- Growth of a strategic, regulated, accountable, transparent organisation
- Selective decentralisation and effective delegation
- National health and disease policies, strategies and plans
- Human resources capacity development
- Planning, monitoring, evaluation and information systems and research
- Setting national level priorities, standards and guidelines
- Sector wide and inter-ministerial coordination
- Health financing and management of financial resources
- Contracting services

State Level

- Leadership
- Joint assessments, planning, monitoring, evaluation and operational research
- Sectoral and inter-sectoral coordination
- Annual management work plans
- Implementation of government health care and services
- Supervision and guidance including of contracted out services
- Referral system
- Epidemiological surveillances

County and municipality levels

- Coordination of health interventions/services
- Assessment and analysis of local health and managerial needs
- Joint strategic planning based on local needs and problems
- Monthly management work plans, reviews and updates on progress
- Implementation of health care and services
- Supervision, guidance and monitoring including of contracted out services
- Referral system
- Epidemiological surveillance

Community level (Payam healthcare centres and communities)

- Implementation of primary healthcare package based on the BPHS
- Community participation
- Referral system
- Weekly work plans by health centres
- Outreaches

Source: National Health Policy 2007-2011

Annex 3: BPHS Key RH Interventions and Services²⁰

Facilities, interventions, services provided	HHP	PHCC	CH	CHD
Education on sexual health				
Referral to higher health services				
Identification and referral of pregnant women in the community to PHCU/C for ANC				
Clinical examination and search for risk factors				
Early detection and timely referral to either PHCC or County Hospital of high risk pregnancies and obstetric complications				
Administration of Tetanus Toxoid, Fansidar, Albendazole, Ferrous sulphate and Folic acid				
Syphilis and urine test				
VCT and, if indicated, PMTCT				
Management of complications				
Normal deliveries				
Timely referral of obstetric complications				
Non-surgical management of obstetric complications and post-abortion care including all the signal Functions of Basic EmoNC				
Surgical management of obstetric complications and post-abortion care including all comprehensive EmONC functions.				
Safe blood transfusion				
IEC				
Distribution / social marketing of condoms				
Oral contraceptives				
Depot injections				
IUDs ²¹				
Surgical contraception				
Training of health care providers				
Reorientation of the services.				

²⁰ Updated in 2011

²¹ After having received the required theoretical and practical training

Annex 4: Levels of Reproductive Health services

Level	RH related activities	Requirements
<p><i>Primary Health Care Unit (PHCU)</i>²²</p>	<ul style="list-style-type: none"> • preventive care and health promotion, • antenatal care, • normal deliveries, • post natal care • family planning, • curative care for common & uncomplicated diseases, • early identification and referral for complicated cases to PHCC or CH for complementary management, • home treatment and outpatient care for moderate malnutrition • Training activities of community-based health cadres. 	<ul style="list-style-type: none"> ▪ Basic Examination room for ANC, PNC and FP ▪ Clean delivery equipment ▪ Delivery couch
<p><i>Primary Health Care Centre (PHCC):</i></p>	<ul style="list-style-type: none"> • BEmONC 7/24 • laboratory diagnostics, • Minor surgery and procedures, such as manual removal of the placenta, assisted deliveries by vacuum extraction, (MVA) of retained products of conception and PAC). Other RH services offered include: • neonatal resuscitation, • family planning,(ARH), • antenatal care, • postnatal care follow up, • curative care (including parenteral administration of medicines and fluids), • stabilisation care for severe malnutrition, screening for STIs/HIV/AIDS, • provision of VCT and PMTCT services 	<ul style="list-style-type: none"> ▪ Minimum of ten beds of which six are reserved for obstetric cases ▪ PHCC may be upgraded to provide CEmONC in the absence of county hospitals. In such circumstance the PHCCs doubles as the second level referral centre. They offer all services of BEmONC and, in addition, also provide safe blood transfusion services and full surgical obstetrics

²² Will be restructured and upgraded to PHCC where appropriated in line with norms and standards for health facilities in South Sudan

Level	RH related activities	Requirements
		<p>including caesarean sections and management of severe uterine bleeding or damage.</p> <ul style="list-style-type: none"> ▪ An upgraded PHCC facility to undertake CEmONC should have an operating theatre.
<p><i>County Hospital(C)</i></p>	<p>Key services offered include gynaecology and 24-hour comprehensive Emergency Obstetric and Neonatal Care (EmONC). Services provided in addition to those provided at upgraded PHCCs include:</p> <ul style="list-style-type: none"> ▪ Basic gynaecological surgery (including tubal ligation and hysterectomy) ▪ Management of complications of pregnancy (e.g. pre-eclampsia, eclampsia, APH, PPH, abortion and anaemia) ▪ Management of complicated deliveries (e.g. eclampsia, obstructed labour,) ▪ Management of puerperal problems (e.g. infection, psychosis) ▪ Surgical interventions: destructive deliveries, curettage and hysterectomy ▪ Referral for specialised surgery (e.g. fistulae) 	<ul style="list-style-type: none"> ▪ Have in-patient facilities for all departments ▪ Capacity to provide CEmONC at all times ▪ Full time functional theatres ▪ Capacity to provide accommodation for key essential staff
<p><i>State and Other Tertiary Hospitals</i></p>	<p>In addition to the BPHS levels of health facilities above, secondary and tertiary referral and teaching hospitals provide essential referral, training and research services.</p>	<ul style="list-style-type: none"> ▪ Capacity to provide all the above at ▪ Capacity to provide enabling environment for teaching