Reproductive Health/Family Planning Service Provision for Returning Populations to South Sudan: Assessment Findings & Recommendations

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i. List of Acronyms

ADEO	African Development and Emergency Organization
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ARC	American Refugee Committee
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communication
BEMOC	Basic Emergency Obstetric Care
CBO	Community Based Organization
CPR	Contraceptive Prevalence Rate
CPA	Comprehensive Peace Agreement
DRC	Democratic Republic Of Congo
EMOC	Emergency Obstetric Care
FGM	Female Genital Mutilation
FP	Family Planning
GNU	Government of National Unity
GOS	Government of Sudan
GOSS	Government of Southern Sudan
HIV	Human Immune Virus
ICRC/RC	International Committee of Red Cross/Red Crescent
IDP	Internally Displaced Persons
IOM	International Organization for Migration
IRC	International Rescue Committee
IUCD	Intrauterine Contraceptive Device
JSI	John Snow International
MCH	Maternal Child Health
MEDAIR	International Humanitarian Aid Organization
MMR	Maternal Mortality Rate
MOH	Ministry Of Health
NGO	Non Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs (UN)
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Clinic Unit
RH	Reproductive Health
SPLA	Sudan People's Liberation Army
SPLM	Sudan People Liberation Movement
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling Testing
WHO	World Health Organization

ii. Map of Sudan

Map available online from UN Cartographic Section, at: http://www.un.org/Depts/Cartographic/map/profile/sudan.pdf

iii. Acknowledgements

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Any assessment of this kind inevitably involves many people and many inputs. Extensive background work was undertaken by a team in Geneva consisting of Frederik Siem, Sage Hyman, and Mourtala Mboup, and Kammerle Schneider in Washington. The field assessment, which is the core of the project and report, was undertaken by Dr Eustace Muhondwa and Dr Datius Kananura Rweyemamu. They worked assiduously and under what were often difficult conditions to generate the information that is reflected in this report. Pauline Muhuhu, ESD Washington, and Dr Solomon Orero, the ESD representative in Nairobi, facilitated the field assessment and made it possible for the assessment team to make their site visits.

No assessment of this kind is possible without input from the informants in the field, and our thanks go to all the people that participated and gave so much of their time. They came from the Ministry of Health and from the health services sector in South Sudan, from the NGO humanitarian relief organizations, and of course from the people in the communities themselves. Our thanks go to all of them for their insights, ideas and suggestions.

Dr Manuel Carballo
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1. Project Background

1.1 Extending Service Delivery (ESD) Project

…the unmet needs for reproductive health and family planning among underserved populations such as the urban and rural poor and displaced people…

The Extending Service Delivery (ESD) Project, funded by the United States Agency for International Development (USAID) Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, International Centre for Migration and Health, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

1.2. International Centre for Health and Migration (ICMH)

ICMH is an organization that specializes in the health and welfare needs of people on the move, including those who are forced to uproot and resettle elsewhere. The number of people moving for political and environmental reasons is growing everywhere, and in many cases is doing so in and around countries that are only just emerging from conflict and are still fragile. ICMH works with national governments, UN agencies, and NGOs to improve the capacity of all relevant partners to ensure they can respond to the health and social needs of all people on the move. It does so not only because it believes the right to health applies to everyone, but also because it believes that by respecting and responding to the needs of refugees and internally displaced people (as well as migrants in general) the public health and welfare of the larger society is strengthened.

2. Project Rationale

…the project is predicated on the belief that despite the twenty- one years of civil war in South Sudan, much can be done to enhance family health and welfare…

As part of its mandate to address the unmet need for reproductive health and family planning and increase the use of RH/FP services among underserved populations, ESD seeks to strengthen the capacity of the national authorities of South Sudan and its partners to respond to the family health and reproductive health needs of internally displaced people and returning refugees. This project, developed and implemented by ICMH as part of the

ESD contribution to South Sudan, set out to assess and describe the reproductive health and family health situation in the target population in South Sudan and identify what, if any, RH-related services are being provided and by whom. The project is predicated on the belief that despite decades of civil war in South Sudan, much can be done to enhance family health and welfare, and in so doing, help improve social cohesion and reduce the potential for social instability and fragility.

3. Aim and objectives of project

The aim of this part of the ESD project was to make a comprehensive assessment of the situation, and define what steps can be proposed to improve the reproductive and family health of displaced people in South Sudan, using a mix of qualitative and quantitative methods,

Specifically the project sets out to:

- assess what RH-related services are currently available to displaced people;
- identify which organizations, including Ministry of Health, are in place;
- assess the overall RH-related needs of the target population;
- assess what displaced people feel are their overall RH-related needs;
- assess what service providers in the region feel are the main RH related needs;
- propose actions that could be taken in support of RH and family welfare.

…reproductive and family health was taken to include maternal and infant health, age at first pregnancy, awareness of modern family planning methods, healthy birth spacing, wanted and successful pregnancy, antenatal care, freedom from reproductive tract and sexually transmitted infections, including HIV, and security from gender based violence…

4. Approach taken

The situation assessment involved three phases of activity. The first was an extensive review of the literature, including published and unpublished reports together with personal and telephone interviews with key informants, including advisers to the national authorities of Sudan. The second phase involved developing of a series of quantitative and qualitative survey instruments for use in the field assessment. The third phase was the field assessment itself, conducted over a three-week period, including briefings and de-briefings of the field team in Nairobi. For the purposes of this project, reproductive and family health was taken to include maternal and infant health, age at first pregnancy, awareness of modern family planning methods, healthy birth spacing, wanted and successful pregnancy, antenatal care, freedom from reproductive tract and sexually transmitted infections, including HIV, and security from gender based violence. UN definitions were used to classify target populations. Refugees were defined

as people who had been forced to flee and had crossed borders. Internally displaced people were defined as people who had been forced to flee but who had fled within national Sudanese borders. Returning refugees and internally displaced people were defined as people who were "returning" from safe havens they had previously fled to, and irrespective of whether they were moving back to their original homes and communities.

5. Contextualizing the situation

5.1 Sudan, the largest country in Africa

…this religious complexity has an immediate bearing on the need for careful tailoring of all health interventions, but especially those to do with reproductive health…

With a geographical area of approximately 2,505,810 square kilometers and a population of approximately 27,000,000 people, Sudan is Sub-Saharan Africa's largest country. The country includes rain forest, savannah, steppe, and desert. In recent years it has suffered from floods and drought – as well as war. More than 400 different languages and dialects are spoken among Sudan's 597 ethnic groups, which are essentially divided into three main groups: the Northerners, consisting of Arab and Nubian groups; the Southerners, consisting of Nilotic and Sudanic peoples; and the Westerners. The two main religions are Islam in the North and Christianity in the South, but traditional African religions are also widespread in these regions. This religious complexity has an immediate bearing on the need for careful tailoring of all health interventions, but especially those to do with reproductive health, and the dominant cultural and social determinants of health.

5.2 South Sudan

South Sudan is made up of ten states: Western Bahr al Ghazal, Northern Bahr al Ghazal, Warab, Unity, Upper Nile, Jonglei, Buheyrat, Eastern and Western Equatoria, and Bahr al Jebel. The current population of the region is approximately 9.7 million, but expected to grow rapidly as refugees and displaced persons begin to return. This rapid population growth, as a result of the return of refugees and internally displaced persons, is expected to be exacerbated by a fertility rate estimated at 6.7.[1] South Sudan's population is also one of

Solomon Orero

[1] UNFPA. Sudan Country Office Annual Report, 2005.

the youngest in the world and as the youth of the country enter their reproductive lives, the impact on population growth could be massive.

5.3 Conflict, unrest and human security

Health in general and reproductive health in particular has been increasingly and adversely affected by conflict and social instability. Human security has deteriorated over the last two decades and remains among the lowest in the world. Sudan attained independence from British rule in 1956, but also experienced two major civil wars. The first ended in 1972 when the South was granted regional autonomy. The second erupted in 1983 when the national government in the North abrogated the agreement giving South Sudan administrative and political autonomy. The protracted war that followed has been complicated, and made further complex, by the religious, ethnic and diversity and divisions in the country and indeed the region. The 21 years of civil conflict essentially separated South Sudan from the rest of the country and eroded much, if not all, of the region's health and social services infrastructure and made it difficult for the quality of life of its inhabitants to be improved or even sustained at its originally low levels.

…health in general and reproductive health in particular has been increasingly and adversely affected by conflict and social instability…

5.4 Conflict and displacement

Solomon Orero

The conflict forced four and a half million people from their homes and communities, and dispersed them throughout the country and into neighboring states. Of the 4.5 million people who sought safe haven elsewhere, half a million fled across borders and into other countries, especially Uganda, Kenya and the Democratic Republic of Congo. The other approximately four million people remained displaced within South Sudan's borders, but outside and away from their original communities. Many of the internally displaced people were forced to flee more than once, and for some of them, their original uprooting led to an almost nomadic type of political flight. During this period a large proportion of families were split up. Many became single-headed "households" with women having to assume new roles and accept new types of personal and social challenges. Gender based violence has become more common than before and a large proportion of the

…the conflict forced four and a half million people from their homes and communities, and dispersed them throughout the country and in neighboring states…

…a large proportion of the population, including those who were not forced to flee, lives on less than a US dollar a day…

population, including those who were not forced to flee, live on less than a US dollar a day, that is to say below the internationally accepted poverty level.

5.5 Impact of war on services

The impact of the two civil wars, but in particular the second, has been to devastate most of the health and social infrastructure of South Sudan (and much of that in the North as well). Despite the fact that Sudan has developed a significant human capital base and has vast natural resources, Sudan remains severely impacted and underdeveloped. Civil war, frequent natural disasters, together with serious political and economic mismanagement, has impeded any real social development. Most public sector services have been eroded, abandoned or replaced by what many people see as unsustainable external humanitarian relief.[2]

5.6 A Comprehensive Peace Agreement

…approximately one third of Sudan's population lives in the area now administered by the GoSS…

On January 9, 2005 the Government of Sudan (GoS) and Sudanese People's Liberation Movement (SPLM) signed a Comprehensive Peace Agreement (CPA) and put an official end to decades of civil war. The CPA outlined a federal system, embodied by the phrase "One Country, Two Systems." The GoS in the North was renamed the Government of National Unity (GNU) and the rebel movement in the South (Sudan People's Liberation Movement/Sudan People's Liberation Army (SPLM/SPLA)) formed the basis for a Government of South Sudan (GoSS). The peace agreement grants the GoSS autonomy for 6 years, after which a referendum on independence will be held. Approximately one third of Sudan's population lives in the area now administered by the GoSS. The Comprehensive Peace Agreement is expected to encourage refugees and internally displaced persons (IDPs) to return to their homes in the South. Many of them have been displaced for more than 15 years and in areas with only minimal infrastructure and without any basic services.

5.7 The case for health and social development

…maternal and newborn mortality is among the highest in the world and planned child spacing very poor…

…health is integral and essential for reconstruction…

As in all conflicts, the health and welfare of displaced people in South Sudan has been badly affected and in many different ways. Nutritional problems have become widespread, immunization of children has been sporadic at best and dependent on external initiatives, and reproductive health has suffered. Unless more can be urgently undertaken to facilitate the health and social welfare of the population, especially returning internally displaced people and refugees, the likelihood of any large-scale return and reconstruction will be unlikely. Health is integral and essential for reconstruction. One of the central goals of the GoSS is to establish new, and/or wherever possible strengthen existing core health sector systems

[2] Available online: http://www.reliefweb.int/rw/rwb.nsf/db900SID/EKOI-6MN7JT?OpenDocument&cc=sdn

capacities. As far as maternal, infant and young child health is concerned, much remains to be done, and as South Sudan enters into its second year of peace, indicators for all these three age groups remain among the worst anywhere in the world. Maternal and newborn mortality is among the highest in the world and planned child spacing very poor. Access to healthcare services, especially RH/FP-related services is virtually non-existent; most couples are unable to make use of services that would allow them to plan and secure the health and welfare of their families.

5.8 Juba as the capital of South Sudan

The GoSS is now establishing itself in Juba, the designated capital of South Sudan. A former garrison town, Juba still remains poorly served and, despite its selection as the capital of South Sudan, lacks many of the key infrastructural features that a capital city requires. Because it never attracted a strong international organization presence the international agencies working in the region are only now beginning to move there from other key locations such as Rumbek, Nairobi or Kampala.

6. Social and health system implications of peace

6.1 Displacement and return

Solomon Orero

The combination of conflict, drought, famine, poverty and underdevelopment has led to one of the largest displacements of people in history. An estimated 4 million people have been forced to flee and seek safety elsewhere. UNHCR, the UN agency with the mandate for protection of refugees, that is to say people who have been forced to cross borders, reports there are approximately 220,000 refugees from South Sudan in Chad, and another 550,000 in Uganda, Ethiopia, DRC, Kenya, Central African Republic, Egypt and Eritrea.[3] Up to two million of all internally displaced are in Northern Sudan and another 1.5 to 2 million are thought to have been displaced in the South. It is estimated that 58% of the anticipated returns in 2006 will involve North to South movement; 26% will involve South-to-South returns; and 16% will be returns to the South from

[3] USAID. Sudan: Complex Emergency Situation Report #10 (FY 2006). 24 February 2006.

neighboring countries.[4] The speed of return remains unclear. An acceleration of returns is expected in coming months and with the advent of the dry season.

6.2 Where will returnees go

…it is impossible to predict with any certainty exactly where people will go to when they begin to move back, but…

It is impossible to predict with any certainty exactly where people will go to when they begin to move back, but the expectation is that large numbers of returnees will choose to go to urban centers such as Juba, Malakal, Aweil, Netui and Wau where they believe they will find work and social services. Internally displaced people and refugees who have become "urbanized" in large camps are not likely to want to go back to rural areas, and indeed if previous examples elsewhere are anything to go by, many of them will have few agricultural skills that would make rural survival possible under the harsh conditions that characterize much of the land they would go back to. The impact of massive returns to these urban centers that have been denuded of any meaningful infrastructure, is likely to be problematic from a services perspective[5] and from the perspective of overcrowding.[6]

6.3 The challenge of reintegration

Returnees will face a number of serious challenges. Most will not have jobs. Many will not even have complete families or communities they know or into which can reintegrate. The society they will move back into is not the same as the one they left. From the perspective of reproductive health, women and girls will be at an especially high risk of exploitation, at best, and sexual violence and abuse, at worst. During return and reintegration, women and girls can also be expected to be at higher risk of reproductive health-relation problems than men because they may lack access to vital reproductive health care, especially maternity care. If the destinations of returning migrant populations are unable to provide adequate reproductive

…from the perspective of reproductive health, women and girls will be at especially high risk of exploitation at best and sexual violence and abuse at worst...

Solomon Orero

[4] International Federation of the Red Cross and Red Crescent Societies. Operation Update: Southern Sudan Humanitarian Assistance to Returnees and Affected Communities. 17 January 2006.
[5] UN. Reintegration and recovery of displaced persons in Sudan: A report of the interagency mission 1-17 November 2002.
[6] Ockenden International. An Uncertain Return: Report on the current and potential impact of displaced people returning to southern Sudan. 2006.

healthcare services, there may be an increase in rates of unwanted pregnancy, unsafe abortion, and preventable death linked to pregnancy and childbirth.

6.4 The challenge of healthcare

At the time of this assessment, IDP's and returning refugees do not fall under the care of any particular functioning health authority. Moreover, while most humanitarian relief organizations operating in South Sudan provide healthcare, the extent to which they are able to provide reproductive and family healthcare services varies considerably. So does the level of coverage they have been able to achieve. The sustainability of the services that are being provided is also questionable. In part this is because the conflict and instability has made many regions of South Sudan unsafe, especially but not only for the humanitarian agencies. Now, as the process of peace and reconstruction begins, the primary challenge facing the country will be one of transitioning away from humanitarian relief and towards the development of nationally managed public health and clinical services. To date the GoSS has stated that it will give priority to health, but has acknowledged that little remains known about the extent of the needs that have evolved over the course of the last two decades of war and forced displacement.

…the conflict and instability has made many regions of South Sudan unsafe, especially but not only for the humanitarian agencies…

6.5 The healthcare challenge of return

The social reconstruction of South Sudan, and indeed the country as a whole, will be influenced by the number of displaced people who return and the speed with which they do so. With their return (which is socially and politically highly desirable), the demand for health care services of all kinds, and indeed of other services as well, could easily outstrip the country's capacity to respond in quality and in time. If these services are not seen to be available, experience elsewhere suggests that people could become disaffected and socially active against the authorities who are seen as not responding to their needs. A large proportion of refugees will have been in camps and or situations where they were able to benefit from (and became accustomed to) services provided by expatriate and fairly well funded humanitarian relief organizations. The return to poor or non-existent services will not be easily accommodated.

…people could become disaffected and socially active against the authorities seen as not responding to their needs…

7. Field assessment

7.1 Approach taken

The field assessment was facilitated by three ICMH standardized assessment tools: (a) a health facility survey guide; (b) a knowledge, attitudes, beliefs and practices (KABP) survey instrument; and (c) focus group guidelines and

…(a) a health facility survey guide; (b) a knowledge, attitudes, beliefs and practices (KABP) survey instrument; and (c) focus group guidelines and discussion questions outline…

discussion questions outline. Due to financial and time constraints, the KABP survey was not conducted, but many of the items included in the questionnaire were used to guide discussions with the public and with healthcare-related staff working with relief organizations.

7.2 Rationale for selection of sites

The short duration of the mission and the logistical problems that were encountered precluded a truly cross-sectional representation of the situation throughout South Sudan. Following extensive consultations with officials in UN Agencies and Government health officials at the central and state level in Juba, a decision was taken to limit the assessment to the Central Equatorial State. Senior Ministry of Health officials approved the choice and said they were not aware of any verified inventory of health facilities, and expressed the feeling that the situation on the ground might be even worse than has been previously "mapped" by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and other agencies. The approach taken by the field assessment team was also informed by the OCHA "Geographical Areas of Vulnerability Ranked by Ratio of Population to Health Facilities per County, 2005" map.

7.3 Health facilities and size of return

By juxtaposing the two available UNOCHA maps with other maps it became apparent to the team and to Ministry of Health officials that the southern counties have one of the highest real and expected proportion of returnees to population, and a relatively high number of health facilities. The Central Equatorial State has a number of counties with a population to health facility ratio "as high" as <10,000:1, as well as a "high percentage of returnees". The Central Equatorial State also has a high "potential population increase of >10%" for 2005 (few statistics available to authorities to verify this) and a similar projected increase for 2006 with expected returns as high as >10% of the total population. In selecting the Central Equatorial State, the assessment team and the national health authorities agreed this would provide a "best scenario" picture and that it was understood that most areas of South Sudan would be far worse off.

…the southern counties have one of the highest real and expected proportion of returnees to population…

8. Health facilities

8.1 Facilities visited

The health facilities survey set out to assess the main characteristics of the health facilities serving displaced people or located in areas with large numbers of internally displaced people, returned refugees and migrants (including rural-urban migrants). Table 1 provides a picture of the 16

health facilities that were covered by the assessment in three counties of the Central Equitorial State, namely Juba, Yei and Morobo.

Table 1: Number of Health Facilities visited by category

Type of health facility	Name of health facility	County
Hospitals	Juba Teaching Hospital	Juba
	Juba Police Hospital	Juba
	Yei Civil Hospital	Yei
Primary Health Care Centers	Prisons PHCC	Juba
	MTC PHCC	Juba
	Muniki PHCC	Juba
	St. Bakhita PHCC	Yei
	Tore PHCC	Yei
	Goli PHCC	Yei
	Ombasi PHCC	Yei
	Morobo PHCC	Morobo
Primary Health Care Units	Mundri PHCU	Juba
	Gimunu	Yei
	Limbe	Yei
	Bandame	Yei
	Jombu	Yei

8.2 People interviewed

…the health facilities survey involved in-depth interviews with health care staff, and used ICMH specially prepared interview guides…

The health facilities survey involved in-depth interviews with health care staff, and used ICMH specially prepared interview guides that were used to capture as much data as was possible on themes that ranged from services provided to the equipment and supplies that were available. The surveys also gathered information on the populations in the areas covered by the health facilities, and the problems perceived by them in accessing care.

Table 2 shows the range of informants who were interviewed. In most cases they were the heads of the health facilities in question, or staff delegated to respond by the heads of facilities.

Table 2: Informants interviewed at health facilities

County	Facility	Informant
Juba	Juba Teaching Hospital	MCH Coordinators
Juba	Juba Police Hospital	Medical Assistants
Yei	Yei Civil Hospital	Hospital Matrons
Juba	Juba State Prisons PHCC	Nurses
Juba	MTC PHCC	Medical Assistants
Juba	Muniki PHCC	Doctor
Yei	St. Bakhita PHCC	Administrator
Yei	Tore PHCC	Auxiliary Nurses[7]
Yei	Ombasi PHCC	Community Health Workers
Yei	Morobo PHCC	Certificated Nurses
Yei	Goli PHCC	Enrolled Nurses
Yei	Gimunu PHCU	Community Health Workers
Yei	Limbe PHCU	Enrolled Nurses
Yei	Bandame PHCU	Community Health Workers
Yei	Jombe PHCU	Community Health Workers
Juba	Mundri PHCU	Medical Assistants[8]
Morobo	Morobo PHCU	Community Health Workers

8.3 Focus Groups

…informal but structured discussions designed to generate perceptions on a defined area of interest within a permissive and non-threatening social environment...

The second ICMH survey instrument that was used was a guide for Focus Groups Discussions (FGDs), which are informal but structured discussions designed to generate perceptions on a defined area of interest within a permissive and non-threatening social environment. Three groups of participants were specified: women, youth and health workers. Table 3 shows the number of FGDs that were conducted and with which groups of participants.

Table 3: Focus Group Discussions

Participants	County	Number of focus groups
Women	Juba	1
	Yei	2
Youth	Juba	1
Men	Yei	1
Total		5

[7] The clinical officer in charge of this facility had been away for three months preceding our visit.
[8] This facility is serving the IDPs who are waiting for repatriation. We were informed that some of the health workers who were deployed in health facilities in and around Juba hailing from Yei county were drawn together at this facility.

8.4 Time, budgetary and logistical limitations

It was not possible for the two consultants to cover all the parts of South Sudan that warranted being surveyed. Neither the timeframe nor the budget allocated for the task was sufficient to permit as extensive a coverage as desired. The logistical challenges that were encountered were also limiting. The roads were difficult and at times inaccessible, and transport options were very limited. The field assessment team estimated that a team of at least ten people working for one month would have been required to do justice to the appraisal.

8.5 Lack of standards for health facilities

…as yet there are no standards (normative) for health facilities and the services they are expected to provide…

The team also realized that as yet there are no standards (normative) for health facilities and the services they are expected to provide. NGOs are reviving and managing most of the country's health facilities and there are large differences between the types of health facilities involved as well as in the capacity of the NGOs involved. Structures, numbers and skills of health personnel, equipment and supplies available, as well as the range of services provided all vary considerably.

9. General findings

9.1 Overview

…South Sudan's population of approximately 9.7 million is among the youngest in the world and is expected to grow by three million in the next six years…

South Sudan's population of approximately 9.7 million is among the youngest in the world and is expected to grow by three million in the next six years as refugees and displaced persons begin to return to their homes. This rapid swell in population due to migration, coupled with a fertility rate of approximately 6.7,[9] is likely to place new and difficult demands on all South Sudan's institutions, agriculture and economy. Antenatal care coverage is estimated to be around 16% but even then is extremely variable in quality. There is a near absence of family planning with a contraceptive prevalence rate of less than 1%. The high level of mortality and morbidity (MMR 1,700/100,000) is the fifth highest in the world and surpassed only by that in Sierra Leone, Afghanistan, Malawi and Angola. The war has contributed to a worsening of what was already a precarious nutritional situation and 45% of the under-five population is estimated to be chronically malnourished and to have a mortality rate of 250/100,000.

9.2 Communicable diseases

Many of the deaths in the under five-year-old age group in South Sudan are due to preventable diseases. Currently measles immunization reaches no more than 25% of the eligible at risk population. Poverty and poor health is

[9] Ockenden International. An Uncertain Return: Report on the current and potential impact of displaced people returning to southern Sudan. 2006.

reflected in the TB incidence of approximately 325/100000, and the rate is expected to increase as better diagnosis and reporting becomes possible.

WHO estimates that at the end of 2003, 220,000 women aged between 15 and 49 and 21,000 children were living with HIV/AIDS in Sudan.[10] There is also evidence that HIV rates are increasing, in particular among women. The total (estimated) adult prevalence is 2.6 % in the 15-45 year old age group, and 1.1% among males. In the female population on the other hand it is 3.1%[11]. This could worsen in the context of refugees returning. According to national estimates, the prevalence of HIV infection among vulnerable groups is 1% among antenatal care attendees, 10% among tea sellers who are almost always women in the southern district of Juba, 2% among prisoners, 1% among truck drivers, 1.3% among street children, 4.3% among sex workers and 4% among refugees.

The existing data from Southern Sudan show a varying HIV prevalence rates: 0.9% in the general population in Rumbek (2003), 0.3% in a group of people with tuberculosis in Upper Nile (2001), 7.2% in the general population in Yambio (2000) and 2.7% in the general population in Yei county (2000) on the border with Uganda. The Southern states are the hardest hit with HIV/AIDS because of the lack of health services and health awareness, in addition to their proximity to high-prevalence neighboring countries.

According to a UNICEF survey of four counties in Western Equatoria, approximately 48% of adults had never heard of HIV or AIDS. 5.4% had heard of HIV or AIDS, but were not aware of the problems related to it, while 10.2% did not know about the relationship between unprotected sexual activity and HIV or AIDS. Those who stayed in Southern Sudan during the conflict may attribute an increase in HIV/AIDS prevalence to those who left the area and returned – thereby creating a stigma and possible animosity towards returnees.

9.3 Water and sanitation

…efforts to prevent or control disease and promote good health will remain difficult while less than a third of the people has access to safe water…

A combination of factors, including terrain and climate, has contributed to poor access to clean or plentiful water, and this remains a major preoccupation and priority. Efforts to prevent or control diseases and promote good health will remain difficult while less than a third of the people has access to safe water and is only able to practice poor hygiene.[12] From a social point of view, women and girls will also remain particularly burdened by the lack of access to water since it is they who have the task of

[10] WHO Sudan, Summary country profile for HIV/AIDS treatment scale up, 2004.
[11] UNFPA. Sudan Country Office Annual Report, 2005.
[12] [12] UNFPA. Sudan Country Office Annual Report, 2005

finding and fetching water. This can involve long daily treks and heavy weights. It can also mean repeated exposure to the risk of attack and sexual assault.

9.4 Culture, tradition and health

Culture and tradition also have a significant impact on the reproductive health of women in South Sudan. Sudan has the highest prevalence of female genital mutilation in the world. Although more common in the North, there is good evidence that the practice is spreading among internally displaced people who never practiced it before but who see it as a way of acculturating and being accepted by their host communities.[13] Age at marriage is also very low and coming down as a result of HIV/AIDS and the belief that younger women are less likely to have been exposed to the disease. The combination of early marriage (often forced), female genital mutilation and the growing fear, of the spread of HIV/AIDS, is seriously impacting the physical and psychosocial health of girls and women. Both FGM and early marriages can result in severe, and sometimes fatal, biological and psychological effects. The 'culture of silence' surrounding gender based violence (GBV) has similarly produced a social context in which women have few if any recourse to violence, rape and systematic abuse.[14]

9.5 Health infrastructure

Two wars, the chronic lack of stable social conditions, the lack of investment and loss of health personnel has left the national health infrastructure without facilities, equipment and human resources. This is not to say that the country has not continued to produce physicians and nurses, for indeed it has, albeit in increasingly small numbers. But trained staff have been exposed to the same insecurity as everyone else, and many have chosen or been forced to leave. Currently there is 1 physician to 100,000 people, and in many parts of the country the ratio is even less. The near absence of obstetric personnel and the shortage of drugs and primary care facilities means that less than 5% of births are attended by skilled health staff. The civil war in Sudan has disrupted all health service delivery systems. The current health network includes 14 hospitals, 92 Primary Health Care Centers (PHCC) and 567 rudimentary PHC units.[15] The geographic distribution of these facilities and services, however, is poor and many areas are bereft of any type of functioning facility.

…the civil war in Sudan has disrupted all health services delivery systems...

9.6 Health and humanitarian relief organizations

Although a number (growing) of humanitarian relief organizations has tried

[13] Gender Assessment Sudan ISP: 2003-2005

[14] Karame, K. a. L. P. (2005). Sudanese Women and the Peace Process. Oslo, Norwegian Institute of International Affairs.

[15] Southern Sudan Reproductive Health Policy, January 21, 2006.

to take up some of the load, their contribution is seen by some ministry officials as ineffective, unsustainable and often geared more to the interests of the NGO itself than the real needs on the ground. Although this is probably a gross exaggeration, it reflects the frustration of national health authorities at not being able to control either their own programs, or those of expatriate organizations. Many agencies are raising funds for work in the specific area of RH/FP, and the needs of the stable and returning displaced people. UNHCR has begun construction and rehabilitation work on nine primary health care centers and 24 primary health care units in areas that are expected to accommodate large influxes of refugees.[16] IRC has had a presence in the country for over 20 years and is the lead agency to provide reproductive healthcare for refugees during repatriation and resettlement. AMREF has been operating a Health Training Institute in Maridi since 1998, and its activities include the training of midwives and curricula development. The American Refugee Committee (ARC) and the International Rescue Committee (IRC) have provided HIV/AIDS services in Yei and Rumbek since 2003. Their services include voluntary testing and counseling, behavior change communication activities, syndromic management of STIs and condom distribution. John Snow International (JSI) is currently working on a program to rehabilitate primary health care facilities, train medical personnel, procure essential drugs, immunize, and provide access to clean water through small grants awarded to local and international NGO service providers. Fellowship for African Relief is currently providing healthcare services, basic sanitation and food distribution along key transition points that IDPs will pass through on their return home such as Kosti Ferry embarkation, and final destination points such as Northern upper Nile and the Nuba Mountains.[17]

…their contribution is seen by some ministry officials as ineffective, unsustainable and often geared more to the interests of the NGO itself than the real needs…

9.7 Overview of the main current and projected RH/FP inputs

…how many of them will be sustainable or sustained is not possible to say…

In a vast country, larger than any European country, a growing number of organizations are planning activities or have already started them are either underway or planned for the near future. How many of them will be sustainable or sustained is not possible to say but all of them are having, or will have, some positive impact on the health and welfare of the populations in their immediate hinterland. The organizations concerned and the activities they are responsible for are listed below without any commentary on their size or duration.

[16] UN Assistance to IDPs and Returnees in Sudan January to June 2005.
[17] Refugee Studies Center, Oxford University (RSC). Challenges facing returnees in Sudan. 30 November 2005.

9.7.1 Safe Motherhood

Current Activities	Service Providers
Midwife Training & Support	
Provision of technical and financial support for the development of policies and standards on Community Midwifery Training	UNFPA
Provision of reproductive health kits and commodities to service Providers, and has supported capacity-building activities for the newly established Reproductive Health Directorate of the GoSS MoH	UNFPA
On-the-job training for nurses of the Rumbek hospital (Lakes state) that are involved in maternity and MCH services.	WHO-HAC
Antenatal Care	
Provision of TT and iron folate, and prophylaxis now that the LLITNs to an estimated population of 150,000 (JSI Report)	Save the Children through local partner SIDF
Provision of antenatal (TT, and soon to initiate IPT2 and LLITNs), intrapartum, and postpartum services at the village level. Their primary focus is on training TBAs to provide clean, safe deliveries (with the provision of delivery kits) and postpartum care traditionally provided by TBA, for example, home visitation within the first seven days postpartum. Serves an estimated population of 270,000	World Vision
Gangliel site offers antenatal care (TT, iron folate, no STI screening, and provides mothers and TBAs with delivery kits). They have Basic Obstetric Care capacity at 1 PHCC which we visited. They estimate that they assist 1-5 deliveries/month at the PHCC and approximate that TBAs whom they have trained assist 35% of the deliveries.	IRC
Projected Activities	**Providers**
Midwife Training & Support	
Midwifery training to address the limited skills in delivery and care, the critical shortage of qualified local health personnel, and poor maternal health	AMREF
Nurse and midwifery training to strengthen the provision of maternal health care services	ARC
Midwifery training to 30 midwives through skills-provision and practical field experience	CCM
Midwifery training on STIs/HIV and EmOC	MEDAIR
Project to expand midwifery training and integrated reproductive health services. Focusing on 8 key outputs this initiative aims to build a base for rapid expansion of community midwives training and ensure availability of reproductive health supplies at existing service delivery points.[18]	Netherlands Minister for Development Cooperation – Partnering with UNFPA
Technical & Infrastructure Support	
Expansion of the scope of primary health care services though supporting mobile health services, including the provision of a basic Mother and Child Health (MCH) package, improving service delivery	IRC

[18] Narrative and Financial Report Netherlands' Allocations for UNFPA Sudan Projects: Integrated Reproductive Health Services for Southern Sudan and Expanding Community Midwifery Training in the Southern Sudan, Netherlands Minister for Development Cooperation, December 2005.

of TBAs and MCH workers by providing delivery skits and increased training	
Partnership with MoH to develop maternal and reproductive health (MRH) policy for South Sudan based on assessments completed in early 2006.	JSI
Distribution of reproductive health kits and commodities, refresher trainings on reproductive health in emergencies, activities to decrease maternal morbidity and mortality among IDPs and host communities, advocacy for reproductive health services, communities sensitization on existing reproductive health emergency services	UNFPA
Provision of a complete Safe Motherhood Package, including EmOC, to Pochalla and Akobo counties through increasing community involvement, upgrading personnel and facilities and establishing a M&E system	World Relief

9.7.2 Family Planning

Current Activities	Providers
The ARC has operated a reproductive health program in Southern Sudan for displaced persons and local residents since 1999.	ARC (Packard Funded)
As of 2005, 100% of public sector family planning commodities are being provided by UNFPA. These included IUD insertion kits.	UNFPA
Supply of condoms, purchased with limited project funds.	IRC
Additionally, 63% of rural hospitals in about 75% of localities are providing family planning services. [19]	The package provided by UNFPA includes training of service Providers in family planning services and counseling according to WHO criteria
Two potential sources of funding for supplies and services may be available through the US government. First, the USAID regional health coordinator indicated that Child Survival funding may be made available in Southern Sudan; this funding program supports family planning because of the health benefits to children in families where births are spaced. The second potential source is activation of a memorandum of understanding between USAID and the Office of Foreign Disaster Assistance (OFDA) which makes available USAID contraceptives to OFDA-supported programs. [20]	

[19] UNFPA Sudan Country Office 2005 Annual Report
[20] Purdin, S. (2000) "Reproductive Health Strategy for Southern Sudan." Background paper prepared for the Packard Foundation presented to Centre for African Family Studies.

9.7.3 Gender Based Violence

Current Activities	Providers
Advocacy work done by the Women in Law Project in Rumbek is the only gender-specific activity currently underway at the field visit sites of the study.[21]	Women in Law Project in Rumbek
Informational campaigns on early marriage in the Upper Nile[22]	Sudan Women's Voice for Peace
Investigated, evaluated and reported alleged incidents of attacks against civilians, an estimated 30% of which involve sexual violence against women almost exclusively by GoS soldiers.	Civilian Protection Monitoring Team (CPMT) in Rumbek
Hired and trained 60 paralegal aid officers and opened legal aid clinics in nine counties focusing on promoting human rights but also addressing complaints regarding GBV, especially domestic violence.[23]	New Sudanese Women's Foundation
In late February 2006 training conducted with 85 senior military officials on sexual exploitation and abuse and gender issues as part of the National Monitors Training in Juba, organized by JMCO.[24]	UNMIS Gender unit

Projected Activities	Providers
National training of trainers on SGBV policing	UNDP
Life skills based education to ensure that school aged girls, OVCs, boys, and young people both in and outside school have the life skills to prevent HIV and GBV in the 10 states of Southern Sudan	UNICEF
"Primary Health Care Provision to Host Communities and Returnees in Yambio County," which consists of building the capacity of ten community-based organizations (CBOs) in the prevention and mitigation of HIV and GBV	ADEO
"Integrated reproductive health services and information for Southern Sudan," which advocates for RH services by convincing policy makers on certain sensitive topics such as Family Planning and GBV and uses community and religious leaders to increase accessibility to services	UNFPA
Establishment of Community Based Protection Networks in main areas of return, whereby UNHCR organizes six one-week-long workshops for local authorities, community representatives, NGOs and UN agencies on protection principles, human rights, women's rights and GBV, children's rights, IDP, refugee and returnee principles, HIV/AIDS awareness and protection incident reporting guidelines.	UNHCR

[21] USAID, March 2005, p. 43.
[22] USAID, March 2005, p. 43.
[23] USAID, March 2005, p. 20.
[24] UN Sudan Situation Report, 23 February 2006.

9.7.4. HIV/AIDS

Existing Services	Providers
The ***SPLM HIV/AIDS Policy and Control Strategies for the New Sudan*** was drafted in 2001 and the New Sudan National AIDS Council was formed in 2002 to coordinate HIV/AIDS programming in South Sudan.	
Prevention of Mother-to-Child Transmission (PMTCT) treatment available at 14 of their 18 Safe Motherhood Initiative sites in Southern Sudan.[25]	UNICEF
Conducting awareness activities in several Southern communities, notably Yei which is a key stop along trucking routes.[26] Their program is currently in Yei, Lainya, Morobo, and Rumbek counties.[27]	ARC
Active in the South in prevention and home-based care activities. The Council also serves as a member of the Global Fund Country Coordinating Mechanism (CCM) in the North.	Sudanese Council of Churches
A Round 4 Proposal to the Global Fund in Southern Sudan was submitted $28.4 million and approved for two years of funding at $8.8 million.[28] Projected activities include expansion of testing and counseling sites, capacity-building of health personnel, and provision of antiretroviral therapy for 2592 people within five years.	UNDP is the agency responsible managing these funds.
This project represents a major effort to expand and develop primary hea care capacity in Southern Sudan. The project is supporting capacity building at the GoSS MoH as well as awarding sub-grants to a variety of local and international agencies. Two million dollars will support HIV/AIDS activities in the south.[29]	The USAID financed Sudan Health Transformation Project (SHTP)
Four sites (Yei, Maridi, and two in Rumbek) have been established as initial HIV sentinel surveillance sites through a, HIV Prevention and Care: Rapid Interventions in Southern Sudan (RISS).[30] This project will also provide VCT services for demobilized soldiers and their partners, assess blood supply needs, and assess potential sites for ART care.	US CDC funded project

9.7.5. Adolescent health

Existing Services	Providers
HIV/AIDS education for teachers[31]	UNICEF/ Norwegian Refugee Council
HIV/AIDS Education activities include youth focused programming	ARC
In Maridi a Life Skills Center for Youth has been established. There are numerous programs for youth, many of which focus on vocational skills training, but there are also programs that aim to increase knowledge and awareness about reproductive health and HIV/AIDS/STIs.	Ockenden International
Adolescent and Youth RH and life skills education among returning IDPs, Refugees and Host Populations	UNFPA

[25] UNICEF Southern Sudan. Monthly Report, October 2005.
[26] USAID/REDSO/ESA. Gender Assessment Sudan ISP: 2003-2005. March 2003.
[27] JSI Research & Training Institute. Sudan Health Transformation Project (SHTP). 2006.
[28] WHO. Summary Country Profile for HIV/AIDS Treatment Scale-Up: Sudan. June 2005.
[29] JSI Research & Training Institute. Sudan Health Transformation Project (SHTP). 2006.
[30] JSI Research & Training Institute. HIV Prevention and Care: Rapid Interventions in Southern Sudan. 2006.
[31] http://www.unicef.org/uniteforchildren/youth/youth_29322.htm accessed March 4, 2006.

10. Field Assessment of Health Facilities

10.1 Hospitals

Three hospitals were covered as part of this assessment. Two were in Juba and one in Yei. The Juba Teaching Hospital is the main public hospital in Juba; The Juba Police Hospital is managed by the police force, and the Yei Civil Hospital is run by Norwegian People's Aid. WHO believes the level of competence is generally low in all the hospitals and the medical coordinator of one NGO feels the performance of at least 60% of all the qualified nurses from a former garrison town hospital is extremely low. This view is not unique to him. A Sudanese doctor claims that only the nurse-in-charge of each ward is now authorized to give prescribed medicines because doctors have found that many of the nurses are functionally illiterate.

…WHO believes the level of competence is generally low in all the hospitals…

10.1.1 Juba Teaching Hospital

Juba Teaching Hospital is the largest public tertiary hospital and "referral center" in South Sudan and includes a training center for midwives. The informants who were interviewed at the Juba Teaching Hospital were full time employees of the Ministry of Health. The hospital is reported to serve the general population, including internally displaced people and returning refugees. The Juba Teaching Hospital has no neonatal care unit, nor does any such facility exist anywhere else in South Sudan.

…has no neonatal care unit, nor does any such facility exist anywhere else in South Sudan…

10.1.1.1 Observed facilities and equipment

The facilities/equipment observed by, and reported to the assessment team in the Juba Teaching Hospital consisted of:

- 16 beds
- 3 delivery rooms
- 3 intensive care rooms
- 8 maternal resuscitation equipment
- 4 neonatal resuscitation equipment
- 1 laboratory
- 1 refrigerator.

10.1.1.2 Equipment

…no blood transfusion unit and there were no incubators…

There was no blood transfusion unit and there were no incubators in the hospital and although the survey team were told the hospital has an outreach capacity and does home deliveries, there were no TBAs attached to the hospital and very little evidence of any trained midwives. In addition the following items were said to be missing or in urgent need of replacement:

- sterile gloves
- artery forceps

- antiseptic receptacle for boiling
- autoclave
- sterile delee suctions
- portable baby scale
- sterile amnihook
- equipment for electric and manual vacuum aspiration.

In general all the equipment was old, in visibly poor condition and most of it was in need of replacement.

…in general all the equipment was old, in visibly poor condition and most of it was in need of replacement…

10.1.1.3 Reproductive health-related activities

Safe motherhood

A recent report by JSI estimates that there are approximately 456 vaginal deliveries per year and approximately 7-10 C-sections per year at the Juba Teaching Hospital, which suggests a very low attendance. The same report suggests that neonatal mortality in South Sudan is very high. The staff interviewed by the assessment team reported that Juba Teaching Hospital provides - in one capacity or another - the services delineated under section 8.1 of the survey instrument, with the exception of prevention of mother-to-child HIV transmission and HIV counseling. The hospital also provides emergency obstetric care.

Postpartum care

…is not currently capable of or providing any surgical care for fistula or FGM...

Hospital staff also said the Juba Teaching Hospital is capable of providing health education, iron and folate prophylaxis, vitamin A supplementation, breastfeeding support and postpartum family planning counseling. However, there was no sign of how consistently it actually does this or whether there is a constant supply of drugs.

Repair of fistula and female genital mutilation-related injuries

The hospital is not currently capable of or providing any surgical care for fistula or FGM but there was general agreement that these are issues of concern and deserve to be given more priority.

Family Planning

Unlike most of the other health facilities visited by the team, the Juba Teaching Hospital is not currently providing most of the family planning methods covered by the survey instrument (section 8.2), but it does nevertheless provide voluntary surgical contraception and natural family planning counseling.

…over the last twelve months the work load on the hospital has become more intense because the growing number of patients…

HIV/AIDS and STIs

The hospital staff says the facility routinely distributes male condoms, and provides diagnosis and treatment of STIs, voluntary counseling and testing

for HIV/AIDS, and treatment of some opportunistic infections. It does not provide female condoms, antiretroviral therapy, counseling for HIV positive pregnant women on mother to child transmission or infant feeding, home based care for people with AIDS, or any community based AIDS prevention education.

Gender based violence

The hospital is said to provide psychosocial support and counseling for victims of rape, and emergency contraception. Staff also said (see below) that there seems to have been a decline in GBV and an improvement in the psychological wellbeing of women. There was no indication of whether hospital staff are engaged in any out-reach work, such as community education and awareness raising about gender based violence. Nor was there any evidence of guidelines or protocols on how to manage or report sexual violence and post-exposure prophylaxis for STIs/HIV/AIDS.

10.1.1.4 Growing load on the system

The assessment team was informed that over the last twelve months the work load on the hospital has become more intense because of the growing number of patients, especially the number of pregnancies, and the higher expectations of patients, especially those returning from refugee camps and other areas where there has been some expatriate humanitarian relief activity. There is also a suggestion that women are reporting fewer incidents of sexual violence and their psychological problems are not as marked as a few years ago. The growing load of patients in the absence of any concomitant improvement in staffing and equipment is nevertheless a constant concern for the staff of the hospital.

...training is sporadically available through expatriate groups but is not part of any systematic attempt to raise the level of the hospital…

10.1.1.5 Training

The staff reported that training is sporadically available through expatriate groups, but is not part of any systematic attempt to raise the level of care of the hospital and the professional capacity of the staff. Ob/gyn training has been provided in the last twelve months. Areas that have not been addressed by the training include the diagnosis of kernicterus and screening and caring for victims of gender based violence. None of the training programs appear to include provision of equipment trainees and this was highlighted by them as a problem.

... the distances women have to cover on foot or using the most rudimentary transport methods that put women with obstetric emergencies at even greater risk…

10.1.1.6 Other concerns

Interviews with staff identified three main areas of need, namely the need for frequent and better training, better and more up-to-date equipment, and improved physical facilities. The main problems faced by women in the region, theoretically being served by the Juba Teaching Hospital, are the distances women have to cover on foot or using the most rudimentary

transport methods. This places women with obstetric emergencies at an even greater risk and discourages many women from even trying to get to the hospital. There was also a consistent feeling among staff that husbands' attitudes are a problem and often the reason why women try to access care late or not at all. This, coupled with the expense (however small) of trying to get to the hospital and pay (officially or not) for treatment and drugs (if available) and the generally poor knowledge about needs and complications in pregnancy, remains a major challenge to improved reproductive health.

10.1.2 Juba Police Hospital

The Juba Police Hospital is administered by the Police Force. The hospital serves the Police Force and families; it also serves the general public, including displaced people and returning refugees On the whole, it is poorly and inadequately staffed. For example the physician who had been recently appointed to administer the hospital has disappeared and has not been replaced. Nothing appears to be known about why he left or where he has gone. In general there is a resignation to the loss of staff, including senior staff, as a result of the poor working and remuneration conditions. .

10.1.2.1 Staffing

The hospital staff consists of five medical assistants, four laboratory technicians, two midwives, four village midwives and four theatre attendants. The hospital is, in effect, run by low-qualified staff and there is no evidence of supervision by, or accountability to, any other higher authority. Staff whom were interviewed, all said that the absence of physicians and other senior medical staff makes it difficult to provide the type of treatment patients require. As one person said "I feel that this hospital lacks the qualities of a real hospital. It has no doctors, only Medical Assistants, and no laboratory staff. We admit patients but we cannot even feed them. There is no laundry services, no running water, and no drainage. Sanitation in the hospital is poor."

"I feel that this hospital lacks the qualities of a real hospital. It has no doctors…"

…the hospital has no electricity supply and the standby generator has not been running since January 2006…

10.1.2.2 Reproductive health-related activities

Maternal and newborn care

Although the hospital can and does provide essential prenatal activities, it has no capacity/supplies for tetanus immunization or micro-nutrient supplementation. Nor does it provide family planning services. The hospital is not in a position to conduct deliveries and all complications of pregnancy and delivery are routinely referred to the Juba Teaching Hospital. The Juba Police Hospital nevertheless has a delivery room and midwives, an equipped operating theater and four theatre attendants. It does not perform surgery, however, because there is no surgeon or obstetrician/gynecologist. The fact that the hospital has no electricity supply and the standby generator

has not been running since January 2006 due to lack of fuel is an additional key factor.

HIV/AIDS

The hospital does not test for HIV but does provide some occasional counseling on HIV prevention. It nevertheless has some limited capacity for diagnosing and treating sexually transmitted infections, which in the case of this region involve high rates of syphilis and gonorrhea.

10.1.2.3 Equipment

…most of the equipment it has is in poor condition and needs to be repaired or replaced…

The Juba Police Hospital is poorly equipped to say the least. Most of the equipment it has is in poor condition and needs to be repaired or replaced. Most of the equipment listed in section 4 of the survey instrument, and relevant to reproductive health is not available.

10.1.2.4 Training

There has been no recent training of staff in the area of reproductive health, and the need for further training as well as equipment, better facilities, and community out-reach was consistently highlighted. The staff feel they are unable to function adequately and this is confirmed by the comments of other observers who have assessed the situation.

10.1.2.5 Other concerns

…the problem of absentee fathers and young people who have no guidance on sexual or reproductive health issues…

Many of the same patient-care problems identified by the staff of the Juba Teaching Hospital were also highlighted by the staff of the Juba Police Hospital. They include the distances women and other patients have to travel, the lack of any adequate or safe transportation system, and the cultural attitudes of men with respect to women and maternal health. There was also frequent mention of the problem of absentee fathers and young people who have no guidance on sexual or reproductive health issues.

10.1.3 Yei Civil Hospital

The Yei Civil Hospital is a public hospital currently being managed by the Norwegian People's Aid (NPA). The informants interviewed could not estimate the population served by the hospital other than to say that as a public hospital it is open to everyone and thus also caters to displaced people and returning refugees.

10.1.3.1 Staffing

The hospital is relatively well staffed with 3 physicians, 2 medical assistants, 33 nurses, 4 midwives, 3 traditional birth attendants and 6 laboratory technicians.

10.1.3.2 Equipment

…lacks any equipment for maternal resuscitation, neonatal resuscitation, and has no capacity for providing blood transfusions…

The hospital has 133 beds, one delivery room and one intensive care room. It also has an incubator and two laboratories. It nevertheless lacks any equipment for maternal resuscitation, neonatal resuscitation, and has no capacity for providing blood transfusions. It has no significant refrigeration system. Although staff said it was also responsible for out-reach work, such as home deliveries, there was no evidence of the equipment (even basic) that would normally be associated with home deliveries. Most of the equipment listed in section 4.5 of the survey guide is available but a lot needs replacing. Only very essential commodities such as surgical needles and catgut, syringes and needles, tape measures, portable baby scales, sterile cord clamps, sterile amnihooks, ambubags, and vacuum aspiration equipment (manual and electric) were visibly available, although exact numbers were not provided.

10.1.3.3 Reproductive health-related activities

Maternal health

The hospital provides routine malaria prevention, routine syphilis testing and treatment, iron and folic acid prophylaxis, vitamin A supplementation, antihelminthic treatment and insecticide treated nets (ITN). On the other hand, it does not provide diagnosis/detection and management of antenatal complications, health education/counseling about pregnancy-related topics and tetanus toxoid immunization.

Emergency obstetric care

The hospital is equipped for and provides delivery care, and has a limited capacity to manage emergency obstetric cases. It is basically equipped for and provides essential newborn care as well as post-partum care.

Family planning

… there does not seem to be any proactive attempt to increase the demand or to introduce other methods and/or reach out to women…

The only services provided are family planning methods for men. As part of this service condoms are provided, but the demand is said to be low and there does not seem to be any proactive attempt to increase the demand or to introduce other methods and/or reach out to women.

HIV/AIDS

HIV/AIDS prevention methods and treatment include male condoms, diagnosis and treatment of STIs, treatment of opportunistic infections and counseling for HIV positive pregnant women on infant feeding choices. There are no female condoms, VCT, home care for people with AIDS and community based AIDS prevention education. Even though there is a VCT centre in the hospital compound managed by ARC (American Relief Committee), the informant reported that the hospital does not provide VCT and PMTCT services.

10.1.3.4 Work load

Just as was the case in the Juba Teaching Hospital, there is a general feeling that the work load is increasing rapidly, including the number of pregnancies and complicated pregnancies. The return of internally displaced people and refugees is seen as part of the reason, but there is also a feeling that expectations for health care are also rising. Unlike the reports from the Juba Teaching Hospital, staff at the Yei Hospital also feels that the incidence of sexual violence is growing and that more of the women who are being seen are coming with severe to moderate psychological problems. The fact that the hospital does not provide any services on gender based violence or post-exposure prophylaxis stands out in this respect.

10.1.3.5 Training

The informant reported not having received any training in obstetrics/gynecology during the last twelve months, but there was general agreement that training is urgently called for, not only with respect to reproductive health.

10.1.3.6 Other concerns

…the main problems women face with respect to reproductive health are poor transport and distance from the hospital…

There was agreement that the situation is serious and that much more needs to be done to re-invigorate the capacity of the hospital system to respond to the growing pressure of demand. There was also agreement that the main problems women face with respect to reproductive health (essentially seen in terms of safe motherhood) are poor transport and distance from the hospital. In addition poor security and risk of sexual violence were mentioned as priority concerns.

10.2 Primary Health Care Centers (PHCCs)

10.2.1 Overview of Primary Health Care Centers (PHCCs)

Eight centers were visited and assessed. All but one of the eight are poorly staffed in terms of both numbers and professional skills mix. The one exception is Muniki PHCC which is headed by a physician and appears to have a “reasonably good” complement of staff. The number of health workers in PHCCs ranged from 3 in two centers to 31 in Muniki. Although PHCCs are supposed to be headed by a Medical Assistant, three of the centers visited, Morobo, Goli and Ombasi, did not have one.

10.2.2 Reproductive health-related activities

Provision of RH/FP/MCH is essentially done by nurses, midwives, village midwives, MCH workers and TBAs. To what extent within each of these professional groupings there are standards for the content of the services

provided, or indeed for the professional training of the staff is not clear. Nor is it clear what the level of proficiency is but it is clear that none of them are assigned to deal with obstetric emergencies, all of which have to be referred to the Juba Teaching Hospital or the Yei Civil Hospital. In view of the negligible transport options, it is not clear what the referral of emergency obstetric cases means or possibly results in. One of the more common methods of transport consists of a wooden chair attached to the latter part of a bicycle (see photograph). Moreover, the fact that only 12 of the 85 health personnel assigned to PHCCs are midwives means that most PHCCs have to rely on what are sometimes poorly trained and supervised personnel for essential reproductive health care. Only Munuki appears to be poised to provide decent quality RH care by having 10 trained midwives on its staff. Indeed in general MCH-related workers are in short supply. Only 4 could be identified in Morobo, St. Bhakita, Tore and Ombasi. On the other hand the team saw a high preponderance of TBAs deployed alongside formal RH staff. In Morobo there were 21 and in Tore 14. There were few if any TBAs in PHCCs in Prisons and in Goli. TBAs constitute 42.3 per cent out of the total health workforce.

…it is not clear what the referral of emergency obstetric cases means or possibly results in…

Transport system for emergency obstetric cases

Staffing in Southern Sudan (From WHO-GoSS report p.32)

STATE	**Number of Staff**
Upper Nile	2416
Central Equatoria/Bahr al Jabel	1248
Jonglei	1263
Eastern Equatoria	954
Warrap	868
N Bahr el Ghazal	686
Western Equatoria	679
Unity	576
Lakes	459
W Bahr el Ghazal	174
Total	9344

10.2.3 Staffing at PHCCs

Position		**Juba**			**Yei**				
		Munuki	MTC	Prisons	Morobo	St. Bakhita	Goli	Tore	Ombasi
Proprietor		*NHI*	SF	MoH	AAH	Catholic church	Open Doors	AAH	AAH
Doctor	*Male*	*1*	0	0	0	0	0	0	0
	Female	*0*	0	0	0	0	0	0	0
Medical assistant	*Male*	*1*	2	1	0	0	0	1[32]	0
	Female	*0*	0	0	0	1	0	0	0
Nurse	*Male*	*1*	0	0	1	0	1	1[33]	0
	Female	*4*	1	1	0	2	1	1[34]	0
Midwives	*Male*	*0*	0	0	0	0	0	0	0
	Female	*10*	1	0	0	0	0	1	0
Community health workers	*Male*	*0*	1	0	0	0	0	1	2
	Female	*0*	0	0	0	4	0	0	0
Laboratory technician	*Male*	*1*	0	1	0	0	1	0	0
	Female	*3*	1	0	1	2	0	0	0
Logistician	*Male*	*0*	1	0	0	0	0	0	0
	Female	*0*	0	0	0	0	0	0	0
Village midwives	*Male*	*0*	0	0	0	0	0	0	0
	Female	*6*	2	0	0	0	0	0	0
(TBAs)	*Male*	*0*	0	0	0	0	0	0	0
	Female	*4*	1	0	21	1	0	14	6
MCH workers	*Male*	*0*	0	0	0	0	0	0	0
	Female	*0*	0	0	1	1	0	1	1
Total		***31***	**10**	**3**	**24**	**11**	**3**	**20**	**9**

[32] Has been away for three months; believed to have taken another job.
[33] Both were auxiliary nurses, the male auxiliary nurse assumed clinical duties while the female auxiliary nurse did the dispensing.
[34] Same as for footnote no.4

10.3 Primary Health Care Units (PHCUs)

10.3.1 General overview

…the PHCUs in Yei operate only three times a week in order to allow the poorly paid health workers to engage in other income-generating activities…

The almost-closed PHCU in Gimunu.

The four primary health care units that were visited in Yei and in Juba appear to be reasonably well-equipped. The PHCU in Juba which is located in a camp for internally displaced people is headed by a medical assistant who is assisted by another retired medical assistant. It has a full complement of staff, and during the team's visit there were a number of health workers who had been laid off from their posts in other health facilities in and around Juba, and were in the PHCU helping out while waiting for repatriation or reassignment elsewhere. The PHCU has a regular supply of drugs. Its services are provided free of charge. Even so all the PHCUs in Yei operate only three times a week in order to allow the poorly paid health workers to engage in other income-generating activities in town. Indeed one PHCU operates only two days a week because it faces an additional problem of shortage of drugs. A WHO-GoSS report on the situation refers to the fact that in some hospitals, staff absenteeism averages around 10% per shift.

10.3.2 PHCU staffing

…the NGO which is supposed to be managing the unit has not sent any drugs or supplies since October 2005…

One of the PHCUs in Yei (Gimunu) was virtually closed and collapsing at the time of the team's visit. The NGO, which is supposed to be managing the unit, has not sent any drugs or supplies since October 2005 and in the absence of this, and any investment in physical plant maintenance, it cannot function. This PHCU serves a community with a high percentage of returning refugees and internally displaced people. The community health worker who had worked at the unit on a voluntary basis was no longer active, and the only other health-related worker is the TBA who conducts home deliveries without any form of technical or financial support. In general staffing at PHCUs is inadequate. Nurses, midwives, village midwives and MCH workers make up less than a quarter of the entire workforce, which includes only one fully qualified nurse-midwife.

…the community health worker who had worked at the unit on a voluntary basis was no longer active …

Only Mundri, the PHCU that primarily serves displaced people in Yei and Yambio camps in Juba, appears to have anything close to a full complement of staff for reproductive health-related activities.

Staffing at PHCUs:

Position		**Juba**		**Yei**			
		Mundri	Gimunu	Bandame	Limbe	Jombe	-
Proprietor		MoH	SMC	AAH	ZOA	AAH	**Total**
Medical assistants	*Male*	2	0	0	0	0	**2**
	Female	0	0	0	0	0	**0**
Nurse	*Male*	2	0	0	0	0	**2**
	Female	6	0	0	1	0	**7**
Midwives	*Male*	0	0	0	0	0	**0**
	Female	1	0	0	0	0	**1**
Community health worker	*Male*	3	0	1	1	1	**7**
	Female	1	0	0	0	0	**1**
Laboratory technician	*Male*	1	0	0	0	0	**1**
	Female	0	0	0	0	0	**0**
Logistician	*Male*	0	0	0	0	0	**0**
	Female	0	0	0	0	0	**0**
Village midwives	*Male*	0	0	0	0	0	**0**
	Female	2	0	0	0	0	**2**
(TBAs)	*Male*	0	0	0	0	0	**0**
	Female	22	1	1	7	12	**43**
MCH workers	*Male*	0	0	0	0	0	**0**
	Female	0	0	0	2	2	**4**
Total		**40**	**2**	**2**	**11**	**15**	**70**

10.3.3 Main reproductive health-related problems

…anemia, malnutrition, sexually transmitted infections are the major problems followed closely by unwanted pregnancy and unsafe abortion…

The main reproductive health problems in the areas surrounding the PHCCs and PHCUs vary. In some cases PHCC staff seem more alert to problems and possibly have a better diagnostic and reporting capacity. In general, the PHCCs and PHCUs that were covered by the assessment referred to an average number of seven major reproductive health-related problems. St. Bhakita in Yei reported the highest number of reproductive health problems. Munuki, Prisons and Ombasi PHCCs reported the lowest number, namely malnutrition, anemia and a high incidence/prevalence of STIs in the case of Munuki and Ombasi, and malnutrition, anemia and delivery complications for Prisons. In general the staff in the PHCUs tends to report fewer reproductive health problems than those in PHCCs. Bandane reported the highest number of reproductive health problems, while Limbe had the lowest number, and Gimunu which was virtually closed, even fewer. Table 6 below outlines the types of reproductive health-related problems reported by 50 percent or more of the health facilities covered. Anemia, malnutrition and sexually transmitted infections are the major problems followed closely by unwanted pregnancy and unsafe abortion.

Reproductive health problems reported by the majority of PHCCs and PHCUs.

RH problem	Number of PHCCs reporting	Number of PHCUs reporting
Anemia	8	4
Malnutrition	7	4
STIs	7	3
Unwanted pregnancy	5	
Unsafe abortion	4	3
Miscarriage	4	4
Pregnancy complications	4	4
Delivery complications	4	4

…it can only be assumed that early infant death is common, and indeed so common that it is not routinely reported…

Neonatal problems are not frequently reported but low birth weight is and so is pre-term delivery, followed by respiratory distress problems. It can only be assumed that early infant death is common, and indeed so common that it is not routinely reported.

10.3.4 Equipment

All but two of the PHCCs have beds; the two exceptions are Prisons and Goli. Of the PHCUs, only Limbe has beds – nine of them. All the PHCCs, except Prisons and Goli, have delivery rooms, but among PHCUs, only Mundri and Limbe have them. Four PHCCs had a laboratory, but again the quality varies and is generally bad. One centre, moreover, has a laboratory but no laboratory technician. Maternal resuscitation equipment and neonatal resuscitation equipment is available in only one PHCC, and none of the PHCCs have an intensive care unit, blood transfusion capacity, incubators or refrigeration. Predictably the situation in PHCUs is even worse. As reported above only one unit has beds; two units have delivery rooms. Even though most of the PHCCs and PHCUs conduct home deliveries through ubiquitous TBAs, most of the so-called "safe delivery kits" lack essential items and have not been replenished in a long time. Most of the equipment listed in item 4.5 of the assessment instrument is either lacking or needs to replaced if it is to be usable. Only Tore, St. Bhakita, Mundri and Limbe PHCUs managed respectively by AAH, the Catholic Church, the central Ministry of Health and ZOA, appear to be reasonably prepared to provide essential RH-related care. The equipment missing in most of the centers include:

…most of the so-called "safe delivery kits" lack most essential items and have not been replenished in a long time...

- Penard's fetoscope (missing in 5 centres)
- Thermometer for infants (missing in 7 centres and 3 units)
- Cord scissors (missing in 4 centres)
- Vaginal speculum (missing in 4 centres and 3 units)
- Clean gloves (missing in 4 centres and 3 units)

- Sterile gauze (missing in 4 centres)
- Antiseptic receptacles for boiling instruments (missing in all centres/units)
- Autoclave (missing in all centres and 3 units)
- Sterile delee suctions (missing in all centres and 3 units)
- Sterile amnihook (missing in all centres and units)
- Ambu bags (missing in all centres and units)
- Equipment for vacuum aspiration (missing in all centres and all units).

10.3.5 Work load

…most of the personnel in these primary health facilities feel their work has become more difficult during the past 12 months…

As was found in other settings, most of the personnel in these primary health facilities feel their work has become more difficult during the past 12 months. The number of patients in general has increased and the number of pregnancies has also grown significantly. In addition there is a feeling that many of the patients attending the facilities are expecting more and are hence becoming more frustrated at what can and cannot be done for them. Only in one facility (Goli) did the staff say that the number of patients has gone down. In two facilities there was also a feeling that the number of women presenting with psychological problems has also increased. Staff in four of the facilities also reports that referral had become easier while in the other three they say it has become more difficult. Asked about what would make their work easier and more satisfactory, most personnel agreed it included more training, better referral options, better equipment, better physical facilities, more efficient transport, and more community support.

…more training, better referral options, better equipment, better physical facilities, more efficient transport, and more community support…

10.3.6 Training

The urgent need for refresher training is evident in all the facilities and in discussions with staff. There has been no refresher training in recent years and the staff feels that this is indicative (rightly or wrongly) of how the central authorities see their facilities and the personnel in them. Training would help motivate personnel.

10.3.7 Other concerns

…a large NGO facing the loss of 40% of its senior qualified staff in December 2005 following alleged orders for SPLA personnel to return to duty…

The personnel who were interviewed tended to be silent on the subject of sexual violence, and this may mean that they have already been interviewed (and possible too often) on this issue, or that for cultural and political reasons, they do not want to enter into a discussion on the problem. Another major concern is the attrition and turnover of staff. A WHO-GoSS report referred to one instance of a large NGO facing the loss of 40% of its senior qualified staff in December 2005 following alleged orders for SPLA personnel to return to duty. Similar fears of a massive hemorrhage of key skilled staff have been voiced by other NGO's. One NGO said that of all the community health workers it had trained three years earlier, only 20%

stayed with the organization, and in a 2000 report Richter told of an NGO that reported a 50-70% loss of CHWs after one year.

10.3.8 Overview of reproductive health in primary health care

Safe motherhood

Although safe motherhood is an essential component of reproductive health, among the PHCCs, the range of services provided varied widely. Munuki PHCC is the least comprehensive in its approach. St. Bakhita PHCC provides all the services listed under section 8.1 of the assessment instrument, while Tore PHCC provided all the services with the exception of one (ITNs). The pattern in the PHCUs, which are less in "stature", is slightly different, but in general they are not as well prepared to address safe motherhood and reproductive health. Only two units provide detection and management of antenatal complications, and only two provide routine syphilis testing and treatment.

Emergency obstetric care

The provision of emergency obstetric care was problematic in all the centers and units. Of the eight components of obstetric care listed under section 8.1.2 of the assessment instrument, only one centre (Tore) provides five of them. Partographs, parenteral administration of antibiotics and oxytoxic drugs, manual removal of placenta and other components that might have been expected to be present as a routine part of care, are more often than not missing.

…the provision of emergency obstetric care was problematic in all the centers and units...

Newborn care

PHCUs (surprisingly) seem to have a better record of providing essential newborn care than the PHCCs. Three PHCCs do not provide any of the five components of essential newborn care listed under section 8.1.3 of the assessment instrument, while all the PHCUs provide three or more of these key services. PHCUs also appear to be better prepared than PHCCs for providing the components of essential newborn care listed under section 8.1.4 of the instrument. All the PHCUs provide between four and five of the essential components.

Family planning

Section 8.2 of the instrument was specifically about family planning methods provided. Of the nine that are listed, one PHCC provides six; the rest provide between one and three methods. Natural family planning counseling is done in five of the eight PHCCs. Condoms are provided by only three of the PHCCs, and none offers voluntary surgical contraception. Among the PHCUs only one unit provided six of the methods, the rest provided only two methods each – condoms and either natural family planning counseling. As with PHCCs, the methods offered by at least three of the units were condoms and natural family planning counseling.

…the rest provided only two methods each – condoms and either natural family planning counseling…

STI/HIV/AIDS

Provision of STI/HIV/AIDS prevention, treatment and/or counseling (section 8.3 of the assessment instrument) varies widely. Among the PHCCs only two, namely St. Bhakita and Tore, provide seven and six respectively of the services. Three centers do not provide any services, and the remaining two centers provide two or three services each. The service reported by most centers is diagnosis and treatment of STIs. VCT and community based AIDS prevention education is far less common. The situation among PHCUs is equally unimpressive. One unit does not provide any services related to STIs/HIV/AIDS, and the most "active" unit provides only four of the services.

GBV

No health facility, whether PHCC or PHCU, has any activities in the area of gender based violence, even though the focus group discussions (see below) found that wife battering is common.

Fistula

…the problem of fistula is not at all well understood…

The problem of fistula is not at all well understood. The assessment team had problems trying to explain what the problem is and how it is manifested. The team's visit nevertheless coincided with a short course in fistula repair at the Juba Teaching Hospital, and the facilitator of the course was concerned that there might not be a sufficient number of cases (reported) for hands-on training of course participants.

Female Genital Mutilation

Questions concerning female genital mutilation were met scornfully and the team was repeatedly told that this was a "Northern" practice, that is to say a practice more specific to the Arab tribes in the north of the country. The team nevertheless came across anecdotal information (see above) that there has been a spread of FGM among internally displaced people "acculturating" to northern social customs.

…the concept of adolescence is alien to the region and adolescents do not seem to have been identified as a special group …

Adolescent health

The concept of adolescence is alien to the region and adolescents do not seem to have been identified as a special group that needs a separate package of health interventions. Most informants report that adolescents are seen in their health facilities for the same common problems as everyone else, especially STIs.

Outreach

The concept of outreach was also confusing for many people. Most informants and the health workers referred to home deliveries, and the

team's visit to Yei coincided with a polio vaccination campaign, which was also mentioned as an example of what is being done in terms of outreach.

11. Field assessment: focus groups

A number of focus groups were organized with women, men and adolescent girls. The findings of those focus groups are outlined below.

11.1 Focus Groups with Women

11.1.1 Reproductive Health

Women feel that **anemia, delivery complications, lack of quality healthcare services, hemorrhage and lack of family planning methods** are the main reproductive health problems that women in their communities face. Women are cognizant of the factors associated with these problems and attributed anemia to lack of a balanced diet. They tend to feel that pregnancy and delivery complications, including hemorrhage, are associated with the lack of trained health personnel who could detect the danger signs and advise women on what to do.

11.1.2 Family Planning

On the whole **knowledge about family planning is poor among women**. There is little notion of the methods that are "available" and many women seem to think that the practice of family planning is/should be limited to people who do not want to have any more children al all. There is also a common belief that only married couples have the right to family planning methods (which may reflect medical attitudes as well). However, **women in Juba are slightly more knowledgeable than women in Yei** and know more about different family planning methods, such as the pill, injectables and condoms. Their main source of information appears to be healthcare workers who, according to the participants, do not take time to explain in detail how the methods work.

"…many men here are not doing their part. In most cases we are not in contact with them so as to tell them everything. So we decide to do it secretly because it is you the woman who will die and not the man…"

Solomon Orero

There is general agreement that **under ideal circumstances, most women in South Sudan would like to wait for two to three years between child bearing,** but knowledge on how to prevent the next pregnancy is generally low and influenced by many social, economic and cultural factors that are often beyond the control of women. Women talk about the impact of the war on family health and say that prior to the war they had typically practiced prolonged abstinence. Traditionally, women are expected to leave the husband's home and stay with their parents until the child is old enough to speak and walk. They feel that war and displacement has made it impossible to continue with these traditional ways of planning family size and spacing of children. In addition women tend to rely on counting safe days, but now this is no longer possible because men are "always drunk and unable to exercise self control". They say that when wives insist on abstinence, they are beaten and forced to have sex. Withdrawal is mentioned as another method, but women say this is possible only if the male is sober, which, according to many of them, is rarely the case.

…under ideal circumstances, most women in South Sudan would like to wait for two to three years between children…

There is a general consensus that **men do not approve of the use of family planning methods, even if it is for child spacing**, and that husbands want them to have as many children as possible and as quickly as possible. Women on the other hand want smaller families of four children maximum. They associate delivery complications and maternal deaths with closely spaced child bearing, and are in agreement that because it is women who suffer most in pregnancy and delivery, as well as childrearing, it is they who should be encouraged to use family planning methods and be able to access methods that cannot be easily detected.

"…where men have discovered their wives were using family planning methods they have often beaten them and even divorce them. In other instances husbands have simply decided to marry other wives…"

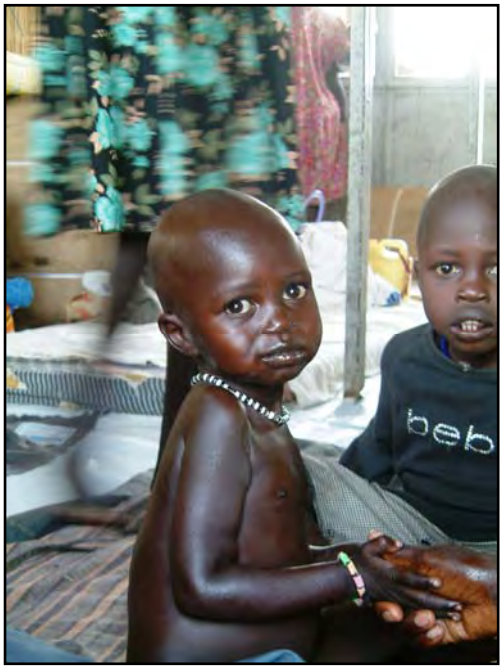
Women talk a lot about the effect of the **current poverty and deprivation that many families face** and feel the current situation makes it difficult to support large families.

However there is also general agreement that **using family planning methods without the permission of the husband puts women in a dangerous situation.** They say that in cases where men discover their wives using family planning methods, they often beat them and even divorce them. In other instances husbands simply decided to marry other wives.

11.1.3 Pregnancy

Women see **early marriage as one of the main factors behind early and frequent pregnancy** but tend to blame young people for this, saying that people are getting married earlier. They put the ideal age for marriage at eighteen years or above.

There is also general agreement that **spontaneous miscarriages are common but that induced abortions are unusual** and limited to young girls whose pregnancies are not socially accepted.



Solomon Orero

Antenatal care services are rarely used, even if they are available (which is often not the case), because women feel that the presence of trained TBAs in most communities means that women can have help if and when they need it. They feel that they do not have to go to health facilities unless the TBAs believe their delivery is going to be complicated.

"…if you have a grown up daughter, then you are safe because she will have to help you in some of the work at home. In this community, men and boys do not perform domestic work…"

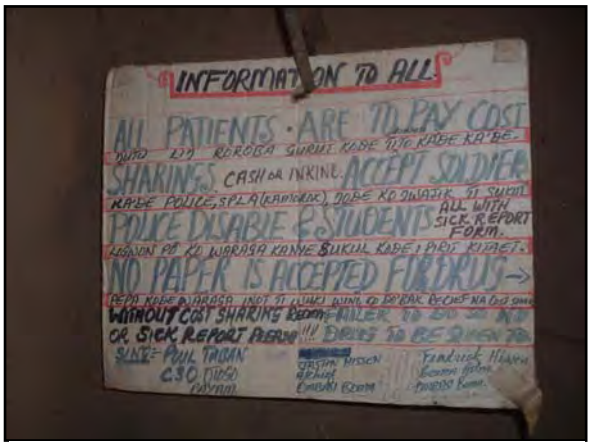
Most women agree that **rest and good nutrition are important for a healthy pregnancy** but that the current situation does not allow this option. They say the situation is too unstable and that women and their families have to be ready to move and do so at short notice, carrying whatever personal possessions they can. Even in situations of relative stability, pregnant women are expected to continue with normal routine domestic chores, and it is felt that only women with grown-up daughters, who can assume some of the daily tasks that fall to women, get the time to rest.

One of the main problems women highlight is the **chronic shortage of drugs in the health facilities** and the fact that even if they do go to health facilities there are usually no medicines available. There is a general feeling that this has led to deterioration in the credibility of the health services. Most facilities go without drugs for long periods of time and even women who can pay, or who are exempted from paying, end up having to buy drugs from private pharmacies, which are often too expensive. The cost of healthcare is a major problem and women say that if they are admitted and cannot afford to pay they are discharged before the baby comes, usually having to return home and wait for delivery time, or borrow money and go

back to hospital. Women's personal belongings are often kept until women, or their families, are able to pay their bills.

11.1.4 Delivery and post-partum period

Women feel that since most PHCCs and PHCUs are not well equipped, **even normal pregnancies can become problematic** and end up in hospitals. There is little evidence that the primary health care system has gained or kept much credibility among women when it comes to the question of managing pregnancy and delivery.



Poster indicating categories of people who are exempted from cost-sharing for health services taken at one of the PHCCs

…women agreed that one of the main reasons women choose to deliver at home is the fact that they cannot afford to do otherwise…

The **cost of delivery** is seen as an obstacle by women. They quote the figure of Sudanese Pounds 2,000 to get an antenatal card and Sudanese Pounds 500 for each following visit. Midwives tend to be paid in kind, for example ten bars of soap and two packets of sweets, as recognition of their services. Women complain that this is no longer a voluntary payment but rather a demanded fee for service. Those who cannot pay are forced to surrender personal belongings as collateral and are given time to go home and gather the money needed to pay. This is a constant source of stress for women during pregnancy.

On the other hand, **deliveries conducted by TBAs are still free,** but women still incur some costs. TBAs expect (but do not demand) some kind of remuneration in kind such as a bar of soap, and many women tend to voluntarily give TBAs even more, such as a chicken or personal clothes. All the women in the focus groups spontaneously suggest that one way of improving reproductive health (pregnancy and delivery) would be to make healthcare, especially antenatal and delivery care, free.

11.1.5 Breastfeeding and newborn care

…breastfeeding should only stop when the woman becomes pregnant again and that this is usually around the second year …

Breastfeeding is seen as the normal thing to do and women think two years is about the adequate period. There is a good deal of concern about **the quantity and quality of breast milk and the cultural taboos surrounding it**. During breastfeeding (up to two years) the mother's relatives do not visit her because their visit may cause lactation failure. There is also a belief that breastfeeding mothers should never shake hands

with visitors otherwise this too will lead to lactation failure. Nor should a woman whose child has died recently visit a mother who is breastfeeding. There is a feeling that these taboos are (and should be) slowly disappearing.

11.1.6 Gender based violence

According to the focus groups **rape was very common during the war.** Soldiers would ambush women when they went to the fields to collect firewood. **Wife beating is now very common** and women are beaten for all kinds of reasons, but especially for refusing to have sex with husbands. This confirms earlier notes taken at the primary health care facilities. Domestic rape is also common and women feel it is linked to the spread of HIV/AIDS. They feel that men are afraid of getting infected through having sex with many women and want their wives to have sex very frequently; when the wife hesitates she is forced to have sex, often having been beaten.

11.1.7 HIV/AIDS

…every time I went (to the hospital), they kept telling me that I had overworked myself and that is why I had a miscarriage. Only much later did they diagnose

Women spoke openly and frankly about HIV/AIDS and are clearly aware of its importance as a health threat. They are also aware of organizations such as the Sudanese Counseling Centre (SCC) which provides education and prevention activities on HIV/AIDS. They feel that most people **have no problems interacting and socializing with people infected with HIV**. On the other hand they say that in many cases the behavior of infected people frightens people, and that at times **people believe that some HIV antibody positive people infect other people** deliberately by not disclosing their status to prospective sexual partners. There is also considerable resentment at the fact that people living with HIV are given free healthcare services while other people have to pay for them. Women also say that s**yphilis is a common sexually transmitted infection,** and that there is no stigma attached to it. They are nevertheless unaware of its health implications and in one focus group a woman said she had had six miscarriages before being diagnosed with syphilis.

11.2 Focus Groups with Men

11.2.1 Reproductive health and family planning

…none of our parents used them and they were able to bring us up. The purpose of marriage is not to limit child bearing but to have as many children as possible. So we don't think these methods are for a good course…

Most of the men who participated in the focus groups **were knowledgeable about FP, but very few are able to identify modern methods.** They mentioned traditional methods such as prolonged post-partum abstinence in which a wife after delivery is sent away to her parents not to come back until the child is old enough to walk and speak. They also report that health workers have told them breastfeeding can prevent another pregnancy. There seems to be a resistance to the idea of modern contraceptive methods and frequently refer to the fact that their parents had done well without them.

Most of the men agreed that **women who use family planning methods without informing their husbands could be divorced,** and some of them recalled instances of this happening. They blame health officials who provide family planning methods to people's wives without involving their husbands. One man told of a man who went to the health facility with a gun to find a health worker who had given contraceptive pills to his wife without his approval. Another man, who is a health worker, said men are strongly opposed to family planning methods. None of the participants felt the use of condoms among spouses was ideal.

…I ask her (wife) every month to tell me when her period stops. I count ten days then I stop having sex with her for the next ten days. This way she does not need her to go to the clinic. We sit together and agree…

11.2.2 Pregnancy

Most of the men agreed that the **age for males to marry is now 20-26 years and under 18 for girls.** They associate early marriages with the war when people were not attending school. They seem to be aware of the maternal and pregnancy complications resulting from early childbearing.

There is general agreement that **sex before marriage is normal for men, provided they do not engage in sex while drunk** because this can lead to having unsafe sex. However, they blamed girls for being the ones who usually initiate sex with men they are sexually attracted to. There is also agreement that **pregnancy before marriage is to be strongly discouraged** and that girls who become pregnant should be forced to tell their parents the name of the person who made them pregnant, and the man involved should be forced to marry the girl.

…sometimes they go early in the morning, stay there the whole day and come back home very late without any medicine. The next day they wake up early and go back and return after sunset and say the doctor did not give them any medicine because the hospital does not have any…

Men agree that it is the duty of the husband to **ensure that the pregnant woman gets nutritious food and enough time to rest**. However, men believe that if she rests too much she shames her husband in the eyes of relatives. Despite being pregnant, women have to prove to the family members and relatives that they are strong. Women are seen as lazy if they seek to be excused from their duties many months before delivery. Indeed, there is a feeling that pregnant women should not excuse themselves from normal family duties until a month or less before they deliver. It is rare for men to accompany their wives to health facilities for antenatal care and men do not believe this is their responsibility or necessary**.**

…in our culture, your wife should respect everybody at your home such as your mother, your father, your sisters and brothers. She has to cook for them, she has to wash their clothes, and she has to be humble every time they ask her to do something. Culturally they say the woman you marry is your wife only at night. During the day, she is the family wife and she has to do everything for them…

Men complain that the quality of **care provided to pregnant women at health facilities is poor and not acceptable.** They complain that women spend many long hours at the facilities but still come back home without being attended. Some women go to the health facilities for more than two consecutive visits without being treated. They believe the shortage of drugs is not a genuine problem and that the real problem is that **health officials steal drugs to sell them outside the health facilities.** However, there is sympathy for health workers who have to work without salaries and without support from communities.

11.2.3 Delivery and Post-partum Care

There is general agreement that the role of the male in delivery and postpartum care is very limited and basically involves **providing money for delivery costs**. Men are aware of the importance of their wives delivering at health facilities but say that most women prefer to be assisted by TBAs at home because of proximity and personal relations with TBAs.

11.2.4 Gender based violence

On the whole there is no disagreement that **wife battering is a common practice,** and men say that wives are beaten for all kinds of reasons, but mainly in the context of excessive drinking by men and because there is a lack of respect by women and for women's demand for equality. Jealousy is a common reason for wife battering, but the most important reason appears to be perceived lack of respect for the husband, in-laws and other husband's relatives.

"…most of the ladies who grew up in the camps in other countries were exposed to foreign cultures. Now they have come back with these cultures of dressing in tight clothes and they just walk like that even here in town. Some men decide to rape them because of their dresses…"

Men also say that **rape was common during wars and was usually committed by soldiers**, but that boredom and lack of employment in the civilian population is another reason now. They explain that the rape of **girls and adult married women is different,** and that girls are raped when they accept gifts but then object to sex. They also believe that girls arouse men by clothing which exposes their bodies. The impact of forced displacement is evident and many men feel women coming back from other countries are bringing with them new habits and values that are causing problems.

"…she may ask you to give her money for buying food, you say you don't have; the child falls sick and she asks you for money to go and buy medicine, you say you don't have. So she starts going out to find men who can give her what she needs …"

There is consensus among participants that whenever rape occurs, **the first step is to take the woman to the hospital for medical attention** and to be checked for HIV or some other STI. Men are very concerned about HIV as a possible outcome of rape. The majority of men say that women and not men offer sex in exchange for money and gifts, but acknowledge that poverty has led women to offer sex in order to get money for basic needs as well as luxuries.

11.2.5 HIV/AIDS

Knowledge about HIV/AIDS, its symptoms and how to avoid infections is good and most men say they know a person infected with HIV, or have heard people give testimonies about their HIV status in churches. There is agreement that syphilis and gonorrhea are common and that HIV/AIDS is something to be afraid of.

11.3 Focus Groups with Adolescents Girls

11.3.1 Reproductive health and family planning

There is general agreement that **young girls initiate sex around the age of 12 years or shortly after puberty**. In most cases, communities have restrictions on premarital sex, but they feel these restrictions are rarely respected and less and less so. Girls also referred to Christian teaching that they are supposed to remain chaste till they marry but say people rarely observe this. Even though participants thought that age eighteen was ideal for marriage as well as for initiating sex, they are aware that girls in their community marry as young as thirteen years old in order not to go to school, or because they are pregnant.

Pregnancies before marriage are said to be common, and girls say that **girls who become pregnant, without meaning to then have to resort to abortion.** Abortions are provided by traditional healers or in health facilities. There are women in all communities who are known as experts for performing abortions.

There is a general belief that there are **no contraceptives for young unmarried girls.** Although they understand child spacing to refer to the interval between consecutive pregnancies they seem to think that family planning is meant for limiting family size. They also know of cases where sexually active girls wanting to avoid pregnancy took pills meant for married adults. They say that it is difficult for girls to obtain contraceptives and that if they want them it is usually the boys who go to get them from health facilities or buy them from pharmacies.

11.3.2 Gender based violence

Girls say that **rape is now rare and especially so since the end of the war.** They believe that soldiers mainly committed the rapes. But they also know that rape still occurs and that in the event of rape the victim is first taken to the health facility for medical attention. If the rapist is known he is apprehended and charged. They are of the opinion that girls are raped because they refuse to have sex when they have received gifts from the individual. Even though adult women may be raped under similar circumstances there is less sympathy for them.

There is consensus that it is **quite common for girls to be beaten by their boy friends**. They explain this is largely due to jealousy and that if the boy sees his girlfriend standing with another boy and suspects that they have a sexual relationship he may beat her. It also happens when the girl does not accept his demand for sex for whatever reason.

Girls agree that **sex for money among unmarried girls is now commonplace,** but that it is the male workers of international relief organizations and peace keeping forces who offer money to women and girls for sex. Because of the high level of poverty, very few women or girls can refuse the money in exchange for sex.

"…most of the boys who do not have money find it difficult to establish a relationship with girls because girls are always after money and they get a lot of it from the relief agency workers…"

11.3.3. HIV/AIDS

In general girls appear to be **well informed about HIV/AIDS and how to protect themselves from getting infected.** Their source of information is largely the various radio programs and sensitization meetings organized by NGOs in their communities. Girls mention the use of condoms as the best way to protect themselves against HIV infections but said that it is men and boys who buy condoms. They are skeptical that girls could buy condoms or insist on their use. They mention syphilis and gonorrhea as diseases people get through sexual intercourse.

12. Conclusions

12.1 General

War, social and economic instability, and massive forced migration have left an indelible and adverse mark on South Sudan and its capacity to provide healthcare in general and reproductive healthcare in particular. Major systemic and institutional gaps now exist in the health system of South Sudan. Not only are healthcare facilities missing or in very poor condition, but there is also a dramatic dearth of human resources, medical supplies, commodities, transport systems, and sanitation. The challenge facing South Sudan, as it begins to move into its period of transitional autonomy, is to see the health sector as a road to promoting human security and social stability. In what is a still politically fragile environment, returnees and the communities they move into must be given major attention and healthcare may well be the vehicle for this. If they are, or feel they are, being abandoned, many will try to return to countries of asylum or become internally displaced again, possibly creating a circular pattern of movement that further destabilizes the country as well as the people who are forced to move.

12.2 Why reproductive health

There are no doubt many ways in which the current health situation of South Sudan could be approached. Improving the reproductive health of the population as a whole, and in particular the reproductive health of the four and a half million people who have been displaced but who are expected to resettle, is probably the most important way. Reproductive health encompasses the health and welfare of the family (no matter how the family is constructed), and healthy functioning families are the basis of social

reconstruction. Unless family health and welfare can be assured it is unlikely that people will be interested in investing in the type of social and economic development activities that are called for.

12.3 Fractionated approach

South Sudan has not attracted the type and quantity of donor support it now requires if it is to move out of the health penury it has come to know. Much of the work being done in the area of health is being done by international NGOs that are more relief than development oriented, and that are not well coordinated among themselves or with the now nascent Ministry of Health. There are good reasons for this in the sense that it is only recently that a reasonably stable government has come into being and with which they can cooperate. Even so, however, the danger is that unless there is more coordination of action and more central planning, a fractionated approach to healthcare could emerge together with multiple, albeit small, parallel healthcare systems whose long-term sustainability will be more linked to the ideas and policies of NGOs and the donors supporting them, than to the Ministry of Health of South Sudan. From a perspective of reproductive health this could be especially complicated because there are signs that not all NGOs share the same view of reproductive health, its importance and its composite parts and how to approach them.

12.4 Return of displaced people

The gradual and much hoped-for return of refugees and re-installation of internally displaced people will not make the delivery of reproductive healthcare, or indeed healthcare in general, any easier. Indeed unless steps are urgently taken to strengthen the country's national healthcare system, the presence of newcomers could quickly overwhelm an already over-stretched system. There are signs that a large proportion of internally displaced people and refugees will return to already overcrowded urban centers that are unable to provide the full range of health and social services needed by local populations, let alone newcomers.

12.5 Need for priorities to be set

Meeting the reproductive health needs that are already present in the local and returning population, as well as those that might emerge in the near future will call for prioritization. The economic and social status of South Sudan and the limited healthcare infrastructure currently in place means that it will be difficult to meet all the reproductive health needs of the country within a short or medium time frame. This assessment has highlighted a number of areas that, if given priority, could contribute to establishing a base of visible progress in reproductive health, and hence confidence by local and returning communities in the healthcare system.

12.6 Primary health care

A strong primary healthcare approach is probably what South Sudan needs the most and can benefit from at this time. Investments in tertiary healthcare, at a time when there is such a marked paucity of personnel and an infrastructure base, is unlikely to produce major results in coverage and reduction of mortality and morbidity. This assessment suggests that the current primary health care system, made up of Primary Health Care Centres and Primary Health Care Units offers an opportunity for action. The fact that traditional birth attendants (TBAs) are so numerous in South Sudan is a reflection that at the grass-roots level there is little else to build on at this time. TBAs, however, should not remain as they are or as the mainstay of the health system. They deserve to be trained, upgraded and better equipped wherever possible. They also need to be supported and possibly gradually replaced by trained nurse-midwives who bring with them a higher level of obstetric competence, and who themselves can be backstopped by obstetricians strategically placed in referral hospitals and larger PHCCs. This is not to say there should not be any major investment in tertiary care, for indeed unless there is a functioning referral system no primary healthcare approach can progress far. But referral facilities should be seen as part of the primary health care approach and located according to the distribution of PHCCs and PHCUs. Nor will any primary health care approach in South Sudan succeed from a reproductive health point of view unless there are major improvements in the way in which emergency cases can be transported to referral services. It also goes without saying that in the absence of a good and continuous drug/commodity supply program, the credibility of any primary health care system is jeopardised.

12.7 Expatriate groups

South Sudan has attracted a large number of expatriate groups. Most are organizations that have traditionally worked in humanitarian relief and not development, but some of them are gradually trying to make the transition (not easy) to development action. One of the frequently raised concerns surrounding these groups and their activities is that many of them do not seem to have a close working relationship with the national authorities. This is not surprising given that South Sudan is only now emerging from a long period of social and political instability in which it has probably been difficult for NGOs and others to identify legitimate and active partners within the country. However, there is a legitimate fear that organizations working independently will create parallel health care systems and in some instances unsustainable expectations on the part of the populations they are serving. Especially from the perspective of reproductive health, moreover, it is not clear how coordinated the expatriate organizations are among themselves and if and to what extent they share the same ideas and positions on what is reproductive health and what can/should be done to protect it.

More attention deserves to be given to coordination of policy and practices among these groups and between these groups and the Ministry of Health.

12.8 Safe motherhood

South Sudan, possibly more so than northern Sudan, has one of the highest rates of both maternal and newborn mortality in the world. There are many reasons for this, poor health in general, under nutrition, and specific nutritional deficiencies are some. In addition, however, the fact that the healthcare infrastructure is weak at best and non-existent in many rural communities, means there has been little opportunity for systematic antenatal and intra-partum care to be provided to the population. The lack of skilled obstetric personnel, the high (relative) price of healthcare, and the historically unsympathetic attitudes to women and their needs have helped detract from healthy pregnancy and delivery. All these aspects of the equation need redressing urgently.

12.9 Family Planning

There are numerous gaps in family planning. Despite the fact that many of the organizations working in South Sudan, as well as the Ministry of Health, have included some reference to family planning in their programs it is not clear how many truly see family planning as a way of reducing maternal mortality and strengthening the welfare of women and families. Nor does it seem as if many of them do in fact provide family planning services. Even if they did, there are numerous cultural and social barriers still to be overcome. This assessment indicates that there are misunderstandings about who is and is not eligible for family planning, what is family planning and ideal family size, the right of women to participate in the decision-making, and attitudes to modern versus traditional family planning methods. These differences in opinion and misunderstandings will continue to cloud the situation unless priority is given to changing people's attitudes and promoting the health and welfare of women as individuals as opposed to vehicles of childbearing and care for others.

12.10 Health facilities

Throughout this assessment it has become apparent that South Sudan is suffering from a dramatic dearth of good health facilities and equipment. Most of the facilities have not been maintained and are now run-down to the point that they are possibly beyond repair. Whatever equipment there is, is also old and needs to be replaced. Safe motherhood in a context where there is poor transportation and poor or non-existent equipment is a contradiction in terms and much more emphasis needs to be given to this by donors.

12.11 HIV/AIDS and STIs

For now South Sudan enjoys a relatively low prevalence of HIV/AIDS (below 3%) but for a variety of reasons is at risk of a rapid increase.

Cultural practices, a decline in age of sexual debut for boys and girls, and significant migration of refugees and others from high HIV/AIDS prevalence countries could combine to produce an elevated risk. The disparity in HIV/AIDS prevalence between women (3.1%) and men (1.1%) suggests the disease is being transmitted by heterosexual men who are taking many sexual partners. Much can and needs to be done to alter the way in which men see sexual partnerships and responsibility. Much more also needs to be done to work with internally displaced women and returning refugee women who may find themselves marginalized and more at risk of having to turn to commercial sex work. To date little has been done to cater to the HIV/AIDS prevention and diagnosis needs of refugees returning from high prevalence countries such as Ethiopia, Kenya, Uganda and DRC, and here again there is a need for focus. In general the shortage of VCT, PRTCT and ART services in the region also calls for attention.

12.12 Gender Based Violence

There is little or no systematic programming of activities to respond to gender based violence. To some extent, violence against women seems to be almost endemic in the culture of male-female relations and the impact of the war has been to make sexual violence as well as violence in general more commonplace and banal. Despite some comments in the assessment that there seems to be a decrease in the incidence of sexual violence, there is reason to believe that in the chaos and frustration that may follow the return of internally displaced people and refugees, sexual violence may increase again. If it does it will serious impair attempts to enhance family welfare and the health of women and girls. Unfortunately the public acceptance of gender-based violence appears to have also permeated much of the healthcare system and it remains far from clear if and how many people working in the health system are interested in dealing with it. Cultural and social acceptance to violence against women also means that victims are unlikely to report it or to expect any action to be taken in response to it. Meanwhile the fact that the country has a large number of relief workers and will probably receive a large number of peacekeepers is cause for concern. Many people in South Sudan already believe (rightly or wrongly) that people coming to work in relief and peacekeeping are responsible for many girls accepting to sell sex.

12.13 Adolescent health

One of the striking findings of this assessment is the fact that the concept of adolescence is not widely understood, including by health-related personnel. Not surprisingly there are few if any programs within the national health system specifically designed or directed to them. On the other hand, it is clear from the assessment that the population of South Sudan is a very young one and that adolescents will become, if they are not already, a key part of the population with their own needs and ways of responding to

reproductive health-related issues. In the case of young people returning from camps abroad and from camps within Sudan, there is also evidence that they have been exposed to new ideas and ways of behaving. Many of them have been in locations managed by expatriate staff and have seen or learned new customs and taken on new values concerning sexual behavior. Ways must be found of giving high priority to this group if they are to be helped to adjust, socially integrate and protect their reproductive health.

Solomon Orero

13. Recommendations

13.1 General recommendations

A number of general recommendations are listed below and are meant as pointers for work that can be taken up by ESD and donors in close collaboration with national, regional and county authorities in South Sudan.

13.1.1 Planning for internally displaced people and refugee returnees

One of the keys to social reconstruction and reconciliation will be the successful return of internally displaced people and refugees to their communities of origin or elsewhere of their choosing. This is easier said than done. For people to be willing to move back they will have to believe it is secure for them and that the communities they are going back to have the types and quality of services required to sustain some degree of quality of life. Under ideal circumstances the movement will be voluntary and the selection of where to live will also be up to the returnees themselves. Ideal circumstances are not likely to be come by easily, however, and there is a danger of overload on communities that are seen, rightly or wrongly, as offering the best opportunities for work and access to services. There is also a likelihood that if and when services are not seen as satisfactory there will be some social and familial unrest and possible the emergence of a circular migration phenomenon that will be chronic and destabilizing from many perspectives, especially from the point of view of reproductive health.

13.1.1.1 Work with national and regional authorities, as well as with relevant international organizations, to develop resettlement plans that provide clear guidance on where, how and with what assistance people should be encouraged to resettle keeping in mind what their health, especially reproductive health, needs are going to be and how they can be met those locations;

13.1.1.2 Develop ways of reaching internally displaced people and returning refugees with culturally and socially tailored information and education on health, especially reproductive health, in particular using existing human health resources such as community health workers, midwives, and others who may need to be trained;

13.1.1.3 Work with all relevant national and international groups to monitor the reproductive health and welfare of returnees, whether they are internally displaced or refugees, in order to respond as quickly and meaningfully as possible to changing conditions, needs and opportunities for intervention;

13.1.1.4 Work with relevant national and international groups to strengthen the social and economic opportunities available to returnees, using such interventions as micro-credit systems and always recognizing that reproductive health is inevitably linked to employment and economic viability factors.

13.1.2 Improved emphasis on reproductive and family health

South Sudan is typical of many countries that have been exposed to long and difficult wars. Coming out of conflict, most countries are confronted by a vast range of needs and problems, including the challenge of peace maintenance and reconciliation of people and ideas. Public health, especially reproductive health, typically finds itself at the lower end of the hierarchy of priorities. This is not because health and the absence of diseases is not appreciated, but rather because the significance of health for social development is not well understood. In the case of reproductive health, not only is the same true, but more importantly there are often many misunderstandings and misgivings about what the concept covers. All too often, reproductive health is understood to be simply a question of family planning for population management purposes and not as a vehicle for social as well as health reconstruction.

13.1.2.1 Work with national, regional and county authorities of South Sudan to develop and strengthen primary healthcare services and approaches, stressing reproductive healthcare;

13.1.2.2 Promote reconstruction of primary healthcare facilities so that they can be capable of providing essential and life-saving reproductive healthcare;

131.2.3 Ensure that all healthcare facilities have the type and quality of equipment and commodities (including contraceptive supplies) to make pregnancy and delivery safe and enjoyable;

13.1.2.4 Work with national, regional and county authorities to prepare and implement plans for primary healthcare services and referral centers that are geographically distributed according to what is known about the pattern of return and resettlement of internally displaced people and refugees;

13.1.2.5 Explore how best to provide simple and low cost transport systems that can be used for antenatal delivery and post-natal care and ensure that women with obstetric emergencies can be transported efficiently and in ways that do not, in themselves, constitute a risk to the mother and baby;

13.1.2.6 Invest in massive and comprehensive training programs for primary health care staff in all reproductive health-related areas, and explore with national, regional and county authorities how best to deploy trained staff in a rational and sustainable way;

13.1.2.7 Work with national, regional and county authorities to adapt or develop technical standards, guidelines and quality assurance with respect to all reproductive healthcare services and ensure these standards and guidelines are made available to all staff;

13.1.2.8 Work with national, regional and county authorities to develop community based monitoring and surveillance activities that cover relevant reproductive health events and ensure the data can be reviewed and discussed with key regional and community healthcare personnel;

13.1.2.9 Address the growing problem of sexually transmitted infections, including HIV/AIDS, especially among young people, and develop or adapt education and training initiatives that can reach as many young people as possible, especially returning displaced people;

13.1.2.10 Assist national, regional and county authorities to build on traditional views about optimal child spacing, including the perceived value of breastfeeding (although not two years exclusive), and use traditional views in order to introduce more modern methods;

13.1.2.11 Work with men and men's groups to more actively promote family planning as a way of improving family life, family economics, and the health and welfare of the extended family, especially the family of the husband;

13.1.2.12 Work with the humanitarian relief and development organizations to make sure they include strong reproductive health components in all their programs and provide their staff with the guidelines and training needed to make these components feasible and effective.

13.2 Specific recommendations

The success of the return and reintegration of internally displaced people and returning refugees, as well as the health and social reconstruction of the population at large, will depend in great part on the targeted impact of reproductive health initiatives.

13.2.1 Give safe motherhood more prominence in all health policies and follow-up with targeted training of nurses, midwives and other primary healthcare staff;

13.2.2 Give more emphasis to the link between safe motherhood and child spacing and ensure that relevant healthcare personnel working with local or international organizations understand how family planning can be used to improve safe motherhood initiatives;

13.2.3 Take steps to establish and sustain warehousing systems for the storage and ready retrieval of affordable (if not free) reproductive health commodities, including contraceptive methods;

13.2.4 Give greater emphasis to developing information and education materials and initiatives that building on traditional concepts about child spacing and that lead into the introduction of more modern child spacing methods;

13.2.5 Develop a roster of all relevant healthcare workers in the regions where refugees and internally displaced people are likely to be resettled and ensure that they are all provided with training on reproductive health, especially safe motherhood;

13.2.6 Give high priority to training on emergency obstetric care and the development of local transport systems that will provide timely, safe and non-risk access to relevant clinical services for women with obstetric emergencies;

13.2.7 Find innovative ways of remunerating healthcare personnel, including through the use of community contributions, basic fee for service

payments, help with housing and food (food for work) and supplemental payments by and through expatriate organizations;

13.2.8 Develop community based ways of monitoring the return of refugees and internally displaced people and their healthcare needs, especially reproductive health, and ensure the information collected is coordinated at a regional level and responded to in a timely and meaningful way, including through discussions with the community itself;

13.2.9 Develop HIV/AIDS information and education programs that stress the need for people with HIV/AIDS to be integrated within the community, as well as how to prevent and manage HIV/AIDS;

13.2.10 Take steps to improve the timely diagnosis and treatment of sexually transmitted infections, including through training local healthcare staff and providing them with the necessary drugs to treat STIs;

13.2.11 Give more attention to assessing the prevalence of fistula and ensuring that fistula repair is possible through local healthcare services or through referral to more specialized centers, including through mobile clinics;

13.2.12 Give more attention to gender based violence and sensitizing communities to its consequences.

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