

**THE ACCESSIBILITY AND QUALITY OF SAFE MOTHERHOOD TO FEMALE
INMATES AT JUBA MAIN PRISON:**

SOUTH SUDAN



BY

GODSON REUBEN LADU JOSEPH

Supervisor: PROFESOR J E STEWART

**A Dissertation submitted in partial fulfilment of the requirements for a Master's Degree in
Socio Women's Law to the Southern and Eastern African Regional Centre for Women's
Law, University of Zimbabwe 2016.**

Abstract

Most surprising fact is that South Sudan has the highest maternal mortality rate in the whole world, with only 2045/100,000 live births. Using a case study approach of Juba main prison PHC, this dissertation (apparently the first of its kind) examines the accessibility and the quality of safe motherhood among female inmate in Juba main prison Juba South Sudan (prison has a clinic) for those women who are either incarcerated and pregnant or those who already have before reaching reproductive age at Juba main (and, in this case study, they are serviced by Prison PHC and Juba main Hospital) and other private and NGO /Religious Hospital facilities in Juba

Using the overarching Women's Law Approach, the writer, himself a safe motherhood specialist of the Reproductive Health Association of South Sudan (RHASS), implements an effective combination of methodologies, including the Grounded and Human Rights Approaches, to highlight the gap between Safe motherhood and Government's promises to realize this maternal health rights standard and its actual failure to do so which has resulted in increasing mortality rates for mothers among those in prison as well those who not in prison. this study data Implements collection methods which encompass a gender- sensitive methodological approaches' (this methods including, research into the relevant literature and law on the subject and also based upon interviews and discussions with carefully selected women respondents, official and government members and key informants and clinic staff). All of this information is collected, sifted, analyzed and presented as evidence of the 'lived realities' of these unfortunate

poor, illiterate and ignorant women. It was established that, while giving birth, many mothers die or suffer life-threatening injuries in the most appalling and avoidable of circumstances in prison or on the way to, from prison or at the few and often far-flung and under resourced clinics and hospitals to which they are forced to journey on motor cycle . one finds that this dire situation is mostly due to the Government's apparent deliberate breach of its duty to realize the women's right to maternal health care by, *inter alia*, failing to: build, maintain, properly equip or administer sufficient and affordable clinics, referral hospitals and waiting women's' shelters; build and maintain critical supporting road and communication infrastructure and failing to train compassionate but frustrated and helpless PHC staff members in basic midwifery skills.

The investigator directly back to the alarmingly insensitive attitude of Government policy makers who boast about their services but blatantly refuse to deliver on numerous commendable health policies which are squarely grounded in numerous regional and international Human Right Instruments which have been ratified by the Government. They apparently feel safe in the knowledge that their .Employer cannot be held accountable for breaching its duty to realize the right to maternal health care because of its deliberate failure to make the right specifically justiciable either locally and internationally. Finally, the writer makes some worthwhile recommendations for both GOs and NGOs, including: undertaking immediate legal reform to make the right to safe motherhood health care justiciable; officially recognizing, supporting and enhancing the skills of traditional midwives whose valuable and critical services have already saved the lives of countless desperate mothers and the immediate purchase and deployment of ambulance motorcycles. These measures can be partly financed by NGO funds which are currently available to the prison PHC.

Declaration

I, GODSON REUBEN LADU JOSEPH, do hereby declare that this thesis is an original piece of Work presented in partial fulfillment of requirement for the degree of Masters in Women's Law, University of Zimbabwe. It was not taken from any previous degree from any other award or academic institution.

SIGNED _____ DATE _____

This work is approved for submission in partial fulfilment of the Degree of Masters in Socio Women's law (MSWL)

Law by the supervisor

SIGNED _____ DATE _____

PROFFESSOR J. E STEWART

SEARCWL

University of Zimbabwe

Dedication

This dissertation is dedicated to my two wives Juan Juliet (JJ) and Chandia Christine (CC) I am blessed to have you as my wives.

Acknowledgements.

My special gratitude goes:

To Anyama Moses Encouraging me to come to the program a May God bless him in a very big way.

To my daughter Guo Christabel you were very supportive and you still worked hard and made me proud despite my absence to assist you and everything else.

To my mother, Sisters Joyce and brother Remo for their support.

To my supervisor PROFESSOR J E STEWART for her instructive guidance throughout the research, from its inception to its finalization.

To my Reproductive Health Association of South Sudan (RHASS) and Brigadier Ajak Deng Director general of human resources and training and Major Harum the officer in charge of female inmate at juba main prison for their full cooperation which Allowed me achieve this Master's Degree.

To the officials in the Ministry of Health, Dr Jamal and Mrs. Lea. and Miss Nnella. I offer my sincere gratitude.

THANK YOU AL

Contents

Abstract	ii
Declaration	iv
Dedication	v
Acknowledgements	vi
Abbreviation	ix
CHAPTER ONE	1
INTRODUCTION	1
Background the concept of the term Safe Motherhood	1
Obstacles to Physical Accessibility	6
Data (information).	7
Statement of the Research Problem.	10
CHAPTER TWO	11
LITERATURE REVIEW	11
Post Natal care and newborn care as access requirement.	20
Safe Motherhood reduce and detach maternal risk at prison PHC worldwide.....	20
Full component of safe motherhood.	22
Safe Motherhood data based storage.	22
Safe motherhood and Gender Related issues.....	23
Structural adjustment program effect on safe motherhood. (SAP).....	24
TBA (Traditional Birth Attendant) effort to preventable death.....	25
The satiable Development Goal (SDG) on safe motherhood. GOAL (3).....	27
Constitution and legal issues.....	35
Grounded Theory	37
The Women's Law Approach (WLA)	40

WHY approach	41
Sample size and Area of study	42
Research Methods	44
Interviews.....	44
Introduction.....	45
Family planning access and quality	46
Clean and safe delivery and postnatal care access and quality for the prison inmate	49
Referral if it becomes necessary.	50
8-performance of surgery e.g. caesarean section.	58
9-performance of blood transfusion.....	58
Why government is failing to comply.	59
Juba main Hospital maternity clinic.	63
Recommendations.....	70
BIBLIOGRAPHY	76

Abbreviation

AIDS Acquired Immune Deficiency Syndrome

ACHPR African Charter on Human and Peoples' Rights

ART Anti-Retroviral Therapy

CARMMA Accelerated Reduction of Maternal Mortality in Africa

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

ECHR European Commission on Human Rights

EMONC Emergent Obstetric newborn care

EU European Union

GOSS Government of South Sudan

HIV Human Immune Virus

ICCPR International Covenant on Civil and Political Rights

ICESCR International Covenant on Economic, Social and Cultural Rights

JMP juba main prison

MDG Millennium Development Goals

MOH ministry of health

MNH Maternal and Newborn Health

NGO Non-Governmental Organization

PMCTC Prevention of Mother to Child Transmission

PHC Primary Health Care

RN Registered Nurse

SN Certified Nurse

SSTC south Sudan Transition Constitution

UNMISS United Nation Mission in South Sudan

UN United Nations

UNICEF United Nations Children's Fund

WHO World Health Organization

CHAPTER ONE

INTRODUCTION

Background the concept of the term Safe Motherhood

Introduction

Given the high maternal mortality in South Sudan and within The Reproductive Health Association of South Sudan's (RHASS) set clinic, our main objective is to improve this clinic as a center for excellence in the provision of the Safe Motherhood package to all women in South Sudan. The objective is the accessibility of high quality treatment that results in the promotion of Safe Motherhood in South Sudan. Therefore, the writer, after enrolling for the degree of Master in Women's Law at the University of Zimbabwe, now has the following questions.

If the condition of Safe Motherhood and its accessibility and quality are currently at worst in the whole of South Sudan, what is the likely fate of the vulnerable women in prison who are living in incarceration? Are they accessing quality Safe Motherhood given that they are operating within the control of the government and its rules and policies? Where in South Sudan do pregnant women as expectant mothers go to access vital facilities for the delivery of their babies while they are in prison? The aim of this research is to interrogate the quality and accessibility of the Safe Motherhood package for female inmates in Juba Main Prison.

The Safe Motherhood package consists of following elements as identified by UNFPA and WHO at their 1987 at Nairobi Conference.

FAMILY PLANNING.

Family planning is the process of consideration of contraception by any individual being married or unmarried who are committed into life long relationship in order to decide if and when to conceive or to have a child. It also involves major decision making of what kind of contraception to take and why. This is always influenced by number of issues which are external such as career, financial problem, disabilities as well complications of one health that may affect the outcome of the pregnancy. Family planning is usually defined as educational package of

Safe Motherhood and social aspect that help individual being minor or adults make a choice freely to either regulate her health or avoid unwanted and an intended pregnancy

Some women come to the prison and are already on family planning drugs as one of choices that they make. If they are not yet on contraceptives, they may choose to do so or may need to do so while in prison. Therefore, all women prisoners need to know that such services are available to them and at their disposal even in prison. Those who are already using contraceptive devices also need to know that their removal or second insertion is possible within the facilities that are routinely available. This service is a necessary component of their human rights.

ANTE-NATAL CARE.

Antenatal care that is some time referred as prenatal care that is a care given to expecting mothers with the aim of preventive health care through provision of regular medical check-ups by doctor or midwives in order to avert potential health threats throughout the pregnancy. Through health screening of the both the mother and the child. This involve maternal physiological support, prenatal nutritional advice like impotent of the prenatal vitamins to both the mother and the child. This can be done through monthly visits (from week 1-28) as well as fortnight visits ranging from 28th week to 36th of the course of the pregnancy and weekly visit form 36th week up time of delivery.

Those women who arrive at the prison already pregnant need to undergo ante-natal care (ANC) as it is a mandatory part of pregnancy care. Therefore, a quality outcome of pregnancy always depends on the quality of ante-natal care available at ANC. Most dangers in pregnancy are screened for and supervised through ANC. In addition, pregnancy monitoring is done through regular checks carried out at ANC.

WHERE DO THESE WOMEN GET PREGNANT?

This is a very important question. One preliminary research finding is that some women come arrive at the prison pregnant. Others get pregnant during the process of their cases because they are given bail and this allows them to go back to the family and in that process they fall pregnant.

Others get pregnant within the prison in unclear circumstances which are subject to investigation by law at the prison.

CLEAN AND SAFE BIRTH DELIVERY.

Birth is natural expulsion of pregnancy hence for clean birth the following are required:

Clean Hands; Clean perineum; clean delivery surface; clean cord cutting; clean cord tying; clean and cord care. The above can be achieved through use of Mama Kit that contained the following clean soap for washing hands and the perineum, a clean plastic piece of 20 -40 cm to provide clean delivery surface for the mother, a clean blade for cutting the cord as well as clean thread to tie the cord. Unfortunately these commodities are not there at the prison PHC.

Therefore a female inmates would have to buy them, if she has money if not she will be exposed to risks of delivery as discussed in chapter four of the findings. The above items are put in one box called Mama Kit or Delivery Kit accompanied by pictorial instruction sheet or manual that includes the reminder information about the birth process and how to effectively use the material as matter of achieving quality and accessible clean birth delivery. This alone prevents many mothers and children from infection that may result in infant and maternal deaths.

Women need to deliver in a good clean environment because they are giving birth to a new life. This is achievable through the attendance of skilled person as required by the WHO report 2012. Where possible they are not delivered by the TBA who may or may not have a full range of medical equipment and supplies such as the Mama Kit.

Postnatal care and new born care

The (WHO 2012) definition of the terms “postpartum period” and “postnatal period” are often used interchangeably, or Separately, well “postpartum” refers to issues pertaining to the mother and “postnatal” refers to those concerning the baby. The terms “antenatal”, “antepartum”, “intranasal” and “intrapartum” refer to issues pertaining to events before or during childbirth

The period after birth delivery is usually known as risk period for both the mother and the child. Especially after the first day, up to week six of the delivery many complication can occur during this period of time.

Therefore the 42 days of care after birth must be attended by both skilled attendance and family members in order to avoid neglectable risk. Most of the findings from the Juba Prison PHC shows that inmates who deliver in the prison are assigned three older fellow women to take care. A specific period of time is insufficient to avert post-natal complication as they lack basic knowledge of detecting upcoming complication on both mother and the baby.

“One care taker was asked assuming the baby is crying she responded of course it's normal for a newborn to cry if the baby doesn't cry it means there is a problem but a midwife was asked the question responded that babies do not cry much after birth so a continued cry means the baby is experiencing a pain sustained during birth or infection. Therefore this explains the need for skilled attendance at postnatal”.

Because this period involves a series of important medical aspects like immunization and routine measures that are taken to minimize infection as the child is exposed to the harsh environment.

Both the mother and the baby need to be given care after birth. This is done by qualified midwives at medical facilities so as to avoid maternal post-delivery complications that can result in maternal and infant mortality, especially from the first day to eighth week after birth and resumption of sex. Therefore, such care is a very important aspect of Safe Motherhood.

Emergent Obstetric New born Care EMoNC

To avert complications during delivery it is always very important that a full obstetric package be at the disposal of the mother. The absence of this service may result in maternal complications ranging from hemorrhage and other major complications that can result in maternal disability or even death.

Discrimination at the prison

Discrimination against women is the subject of gender discussions in all aspects of pre-natal and post-natal development. Therefore, I am looking at discrimination at Juba Prison from another angle where women themselves are discriminated against for reasons that are related to both academic and non-academic power. I am referring to inmates who are either educated or illiterate. Women who are educated and know their rights are given different treatment at the

prison. They sleep well and go for ANC to a private clinic while the non-educated go to the poorly equipped government facilities such as Juba Main Hospital. This clearly shows that education is a tool for the promotion of women's fundamental rights at all levels

Worldwide 287,000 (2002) mothers die every year in child birth. South Sudan contributes 2045 maternal deaths in every 100,000 live births as its maternal mortality figure (MMR) to the world statistic with her infant mortality rate (IMR) of 64/1000 live birth and an under five mortality rate (U5MR) of 99 deaths per 1000, bringing life expectancy of South Sudanese to 55 years. Therefore, it is estimated by the WHO in 2014 that 2.6 million children are still-born and that contributes to a mortality rate of 3 million infants within the first months of delivery, contributing to 44% of deaths world wide of children below 5 years of age.¹

It's estimated that 80% of the maternal deaths are taking place in developing countries like South Sudan which is still undergoing development and addressing its post-conflict health agenda brought about by decades of civil conflict fought between the then Sudan and Southern Sudan. These wars condition have led to our poor health infrastructure and retarded the development of South Sudan's health and human resource development and has become an obstacle to achieving its millennium development goals 4 and 5 respectively, since the launch of the Safe Motherhood Program in 1987 and its subsequent achievement by the year 2000 (UN WHO 2013).

South Sudan's high figure for maternal mortality and infant mortality remains high in the whole world despite the Peace Agreement signed in 2005 between the then rival South and North government that eventually brought South Sudan independence in 2011. South Sudan has only 120 trained doctors according to the Ministry of Health (MOH), very few nurses were also trained during the war. This created a gap for achieving Safe Motherhood despite its welcome launch in 1987. But its objectives had still not been met, including its unmet objectives by the year 2000.

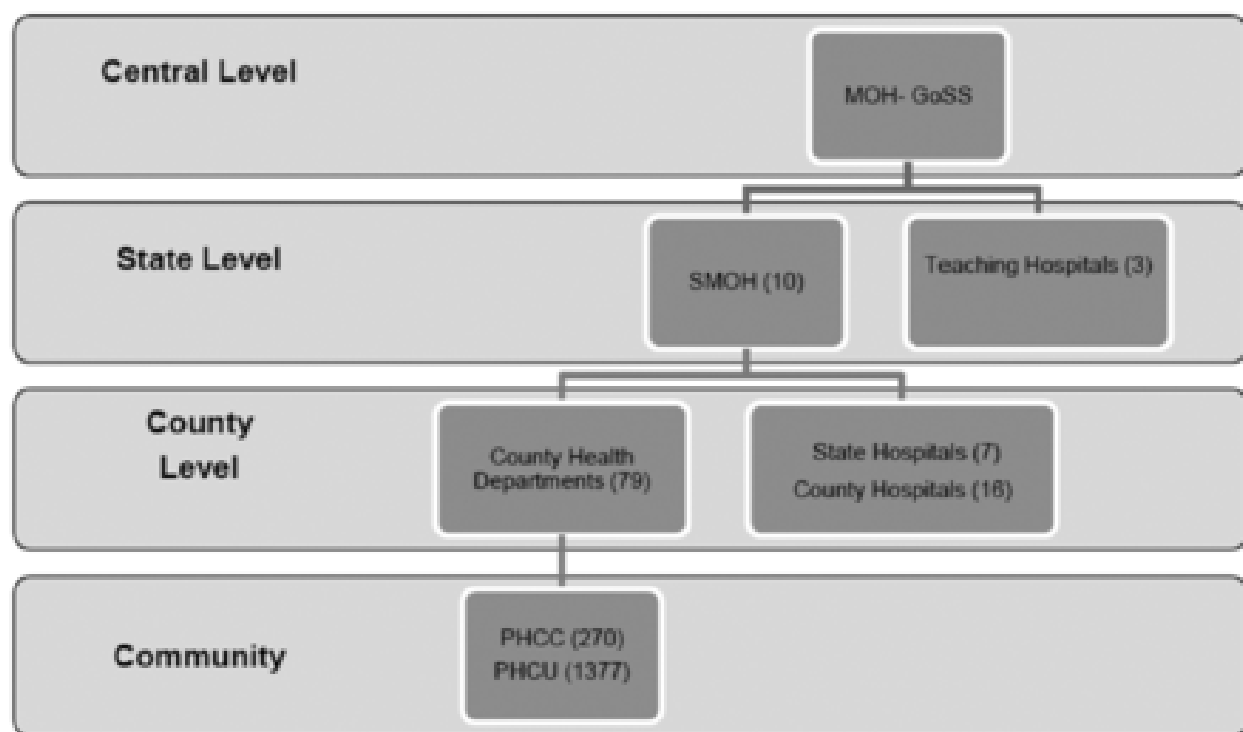
However post conflict attention to Safe Motherhood was prioritized by the South Sudan government and improvements were noted in 3 Hospitals, 7 State Hospitals, 16 County Hospitals

¹South Sudan—Key Indicators/Trends in Maternal, Newborn, and Child Health (2000-2010).

,79 County Health Departments and 270 PHCCs. Juba Main Prison is among these and finally 1377 PHCU in South Sudan.

Most NGOs like UNFPA and WHO through their agents had tried to provide the Safe Motherhood package to all citizens in South Sudan. However, the achievement had been harmed by frequent conflict in South Sudan, lack of accessibility for some of those remote areas of South Sudan that lack social infrastructure for establishment of Safe Motherhood.

This illustration shows effort by the government to establish Safe Motherhood facilities in South Sudan.



2

Obstacles to Physical Accessibility

²**Figure 1.** Ministry of Health organizational structure.
Source. Ministry of Health and Government of South Sudan (2011).

1-the detachment within the society and the Health facility

2-Technical Obstacles

3- The Morbidity and matter of avoiding the 3 Ds i.e.

Delay by the prison as to where the mother shall deliver her baby

Delay on the way as prison personnel struggle in getting same means of transport to move the expectant mother to hospital.

4-Delay at the Hospital in waiting to get the necessary service from the doctors / midwife on duty.

Ability to pay prescription fees.

The economical payable fee at the facility by the female inmate and other user fees changeable.

Data (information).

- Safe Motherhood information
- The education on the advantages and disadvantage of delivery at prison PHCC and Juba Main Hospital.

Oxford Dictionary definition of *access* as the *potential or opportunity to use*. Therefore, in my thesis I observed Access as the right to Safe Motherhood by a pregnant inmate of Juba main prison.

However, it is all about full utilization of the facility ranging from family planning (FP), including Ant-natal Care (ANC), clean and safe delivery, and postnatal care and new born care and provision of full comprehensive Emergency Obstetric Care. In addition, subsequent treatment and prevention of Malaria in pregnancy the latter also ³contributed to maternal

³ South Sudan prison maternal mortality report 2014

mortality in South Sudan and the administering of and prevention of mother to Child Transmission of HIV Aids (PMTCT) must also be mentioned.

In the last past years 1out of 10 woman die annually in Juba Main Prison due to pregnancy complicated related cases or still birth or obstructed labor as Safe Motherhood at the Prison is in a poor state. Every year as Safe Motherhood advocates, we celebrate the International Safe Motherhood Day in South Sudan both international and national NGOs called for the reduction of South Sudan maternal mortality noting that it required equipping all PHCC properly. We drew to government attention all factors for helping the vulnerable women in the village and those who are incarceration and who have no access to Safe Motherhood despite the government of South Sudan's policy of prioritization. Reproductive Health 2008-2011 National Health Policy as Safe Motherhood has fallen short of its achievement within whole health institution in South Sudan because maternal health is still not regarded as a human rights issue.

“Sudan Tribune is a new website and on May 3rd 2016 under the headline” sanitary condition in Torit state prison inadequate, say women's groups”.

The coalition for women human rights parliamentary watch group (CWHRPWG) felt abandoned. They claimed that government had turned a blind eye to the conditions faced by female prisoners in South Sudan's prison. Government at both state and national level had allocated very limited funding for the prison, knowing that it would have dire consequences for female inmates. It left female inmates to stay with sewage and garbage material in their cells. Dina Disan the representative of the women's coalition was quoted as being alarmed by the descriptions of the media and by the condition of the women in Torit prison. ([http://www.sudantribune.com/local_cache_vegnettes/L.2&5xH258/the sewage system_in_the_torit state_prison_7c9dojpg](http://www.sudantribune.com/local_cache_vegnettes/L.2&5xH258/the_sewage_system_in_the_torit_state_prison_7c9dojpg)).

(Below) Are the inmates being visited by the women parliamentarian?



South sudan female prisoners at Juba main prison

‘The coalition expressed dismay claiming that the government had turned a blind eye to the way in which female prisoner were held in South Sudan prison. A state sponsored prison seems to tolerate that fact that female prisoner are housed in cell that contain raw sewage and rotting vegetable waist. Dina Disan who represents the women’s coalition said that she was alarmed by the condition in which women were held in Torit prison.’

Therefore, Juba Main Prison may be not very far from the reality seen in the picture above; being a national prison, little significant effort has been put in by the government and the local Authority and international actors of UNMISS in South Sudan to keep it clean. Safe Motherhood remained a big challenge in the prisons of South Sudan.

However, according to the female government member in charge of Juba Main Prison (JMP), Major Haram adheres to the hope that the government may be struggling day and night to investigate the matter (the government) had campaigned with the Transitional Constitution of South Sudan (TCSS) on the rights of the prisoner and the obligations embedded in the South Sudan Prison Act 2008 (SSPA).

Statement of the Research Problem.

Since the launch of the Safe Motherhood program in 1987 in the former Sudan indicators of implementation of its objectives and goals in South Sudan prison health system remain largely myths. As such the Goals and Objectives include among others the following forms of improvement of the wellbeing of women while giving birth, adoption of The Comprehensive Emergency Obstetric and New Born Care (CEMoNC). This policy emphasizes activities that encourage the rehabilitation of all health institution to be achieved by the year 2000. However, we now see that even by 2000 no Safe Motherhood pillars had been achieved in South Sudan's PHC prison services. After Independence in South Sudan in 2011 the Juba Prison PHC was not improved and renovated as a result provision of Safe Motherhood and remains a challenge up the present date of writing this research paper. The Family Planning Desk and commodity ANC office at Juba Prison has no examination bed and screening equipment. The Delivery Ward has no functional 9 signals for safe birth delivery and no Emergency Obstetric Care; and this in spite of the fact that the PHC has been located there for some time now. It became impossible for pregnant inmates to access quality Safe Motherhood, thus posing a danger to women unless they (the pregnant women) move to Juba Main Hospital to obtain Safe Motherhood services.

CHAPTER TWO

LITERATURE REVIEW

Safe Motherhood is the concept that no woman or fetus baby should die or be harmed by pregnancy or child birth and this can be made possible by providing timely, appropriate and comprehensive quality obstetric care during preconception, pregnancy, child birth and puerperium to women, men, adolescents and new born babies with special emphasis to emergency obstetric care. (South Sudan MOH, Reproductive Health Policy, 2010 pg. 38)

Antenatal care is one of the principle pillars of Safe Motherhood, with the following key components- screening for pregnancy risk factors, disease prevention, detection, and treatment, case referral and health education (WHO, 1999 ¹⁸ Bhasker et al, 2001)¹⁹.

It provides an opportunity for increasing awareness among the pregnant women, their families and their communities about the risks of pregnancy and how to minimize them. It is in most cases the only opportunity that the women or couple may have contact with the health service and so a quality service given may have a lasting impact on future readiness to seek medical assistance (Safe Motherhood newsletter, 1993)²⁰

Lack of antenatal care attendance has been consistently associated with negative outcomes of pregnancy (Ryan et al, 1980)²¹ South Sudan researchers found out that over 67% of all maternal death was associated with nonattendance of antenatal care (Agel, 1994 ²², Wandabwa and Murokora, 1997)²³ similar findings have been echoed in Thika , Kenya (Ruminjo , 1990)²⁴ and in Nigeria (Ekwempu, 1988)²⁵ all these researchers postulate perceived poor quality care as ones of the reasons for nonattendance , it is therefore, important that centers offering antenatal care address that the question of quality care if they are to attract clients and reduce on morbidity and mortality.

The national strategy to improve reproductive health in South Sudan recognizes increased access to quality, goal oriented antenatal care as one of the key pillars of reducing maternal mortality and morbidity and promoting women's health (MOH, 2010)

According to the WHO ¹⁸ the following can be used as guidelines if we have to focus on the quality of Safe Motherhood

- Essential for any Safe Motherhood interventions is the understanding that no intervention can make a difference for maternal morbidity and mortality. For example having good antenatal care services with poor delivery services may not yield desired results.
- Good antenatal care must be provided within a larger context where equity, emotional and psychological support, and a commitment to provide basic health services are priorities.
- Antenatal Care is still a big pillar of Safe Motherhood. With good ante natal Care, there will be reduced maternal mortality rates and infant mortality ratios.
- Antenatal Care services also need to link with quality emergency obstetric services, should the women experience a complication at any time during her pregnancy.
- Finally, good Safe Motherhood services must be part of a continuum of services in which family planning; post abortion care, intrapartum and post-partum care are all provided and support one another.

According to the website on Reproductive health on line ²⁷ the following objectives are used as guidelines if we have to refocus on the quality of Safe Motherhood.

- 1) Promote and maintain the physical, mental and social well – being of both the mother and baby by providing education on danger signals , nutrition, rest, sleep and personal hygiene PLUS the environment of the pregnancy and birth; keeping normal “normal”
- 2) Detect and manage complications, whether medical, surgical or obstetric current problems, not predications.
- 3) Develop a birth preparedness plan: who attends, where, communication / transportation, birth attendant, who accompanies, necessary items (blanket/ towels, clean plastic cover, clean razor blade, clean setting.
- 4) Develop complication readiness plan: where, who accompanies, who stays with children, who makes decisions if the primary decision – maker is not available, finance, transportation and communication.
- 5) Help prepare the mother to breastfeed successfully, experience normal puerperium. And take good care of the child physical, psychologically and socially.

Safe Motherhood:

The quality of Safe Motherhood is determined among other things by accessibility, affordability appropriateness of services and quality of care (Marshal, 1984)²⁸ in Papua New Guinea Nyalander and Adenkule(1999)²⁹ cited inadequate resources, illiteracy and poor services as key hindrances to the achievement of safe motherhood services.

In South Sudan, quality is considered as “ doing the best with the resources available, and doing the right thing in the right way at the right time”¹⁵ in south Sudan safe motherhood is lacking by 92% for all women both in urban and rural areas (SSBS 2006 / 2009)

Even among those who have accesses to Safe Motherhood facilities, clinics, only 42% end up delivering in health facilities. Since perceived quality of care is a key reason for utilization of delivery services (Kusasira, 2004)⁶ it is logical to presume poor quality services as a likely reason for low utilization of the Safe Motherhood services.

The new approach to Safe Motherhood emphasizes the quality of care rather than the quantity. For normal pregnancies WHO recommends the following. The major goal of focused care is to help women maintain normal pregnancies through:

1. Identification of pre- existing health conditions: As part of the initial assessment, the provider talks with the woman and examines her signs of chronic conditions and infectious diseases. pre – existing health conditions such as HIV, malaria , syphilis and other sexually transmitted diseases , anemia, heart disease, diabetes, malnutrition , and tuberculosis may affect the outcome of pregnancy , require immediate treatment , and usually require a more intensive level of monitoring and follow –up care over the course of pregnancy.
2. Early Detection of complications: the provider talks with and examines the woman to detect problems of pregnancy that might need treatment and closer monitoring.

Conditions such as anemia, infections, vaginal bleeding, hypertensive disorders of pregnancy, abnormal fetal growth or abnormal fetal position after 36 weeks be or become life – threatening if left untreated.

3. Health promotion and disease Prevention: counseling about important issues affecting a woman's health and the health of the newborn is a critical component of focused Safe Motherhood. Discussions should include.

- How to recognize danger signs, what to do, and where to get help.
- Good nutrition and importance of rest.
- Hygiene and infection prevention practices.
- Risks of using tobacco, alcohol, local drugs, and traditional remedies.
- Breastfeeding.
- Postpartum family planning and birth spacing.

All pregnant women should receive the following preventive interventions:

- Immunization against tetanus.
- Iron and folate supplementation.

In areas of high prevalence of disease women should also receive.

- Presumptive treatment of hookworm.
- Voluntary counseling and testing HIV.
- Protection against malaria with intermittent preventive treatment and
- Insecticide – treated bed nets.

Quality of safe motherhood services addresses technical competencies of the provider, provider – client interaction and adequacy of essential logistic supply (Bergstrom, 2001)

A study carried out in South Sudan (UNFPA 2010) identify inadequate health education without any guidelines, poor client- provider interaction and clinic overcrowding as some of the contributors to poor quality care.

The sexual and reproductive health policy guidelines for South Sudan (MOH. 2010) ¹⁷ provide details of what is to be done by a health service provider during pregnancy. Some health workers have been trained to offer this package. Provision of iron tablets, weight measurement, recognition of danger signs of pregnancy, taking urine and blood samples for detection of

infections and other diseases like diabetes mellitus, anaemia and de –worming of all pregnant women.

In the developing world, offering quality safe motherhood services stills remains elusive and is compounded by the overwhelmed population pitched against inadequate facilities, lack of equipment and adequate trained manpower (Mat, 1994)³¹

The Ministry of Health in South Sudan prescribes the minimum package in antenatal clinic as:

Information, Education and communication on risk factors and warning signs, provision of hematinic, prophylaxis for malaria, STI screening (including HIV counseling and screening.

The expected minimum staff and equipment's to handle subsequent delivery services are also prescribed (MOH, 2010)

According to the National policy guidelines and service standards for sexual and reproductive Health and rights. It is an approach to Safe Motherhood care to pregnant woman from the pregnancy is diagnosed up to the time delivery. During this time the couple is prepared for a safe delivery of a live baby and the mother is counseled on infant feeding some of the objectives are to:

1. Assess and maintain physical, mental and wellbeing of the mother and her un-born baby.
2. Detect and treat pre- existing conditions or complications arising during pregnancy.

A pregnant woman and her family can prepare for birth before the event occurs- she will need to choose a skilled attendant to assist her at birth and an appropriate birth setting. She will also need to have a necessary money for care, make a decision about how to get where she plans to give birth, and who will accompany her and stay behind to care for the family. She and her family can also gather supplies such as clean bed clothes, perinea pads or cloths and soap.

The issue of who could or should provide Safe Motherhood continues to be widely discussed, despite the extensive implementation of midwife managed programs or antenatal care led by provides other than Obsterician / Gynecologists. The WHO Department of Reproductive Health and research found that clinical effectiveness of midwife / General Practitioner managed care is similar to that of obstetrician / Gynecologist led share care. The most important lesson from this

is that the set of competencies necessary to provide Safe Motherhood is more important than the specific cadre of Health Care provider caring for a woman during her pregnancy.

In addition, while women's response to the midwives' clinic were positive, continuity of care and of care provider was a significant factor enhancing women's satisfaction and building confidence. Care providers should, therefore, seek to facilitate a system of care provision that fosters continuity of both the provider and the care received.

A pregnant woman also needs to develop a plan for emergency transportation with the family in case she develops a complication and needs to seek care. It is important to discuss with families /couples make decisions about when to seek care and where to go. When only one person is responsible for making due decision, it is important to establish an alternate plan for decision – making if there is an emergency when the chief decision – maker is absent. Husband or the mother – in law may be the primary decision – maker and should make a plan for decision – making. However in prison the officer take this decision making process on behalf of the inmates

The family should be encouraged to save money or learn how to access community emergency funds so that necessary funds will be available in the cast of an emergency. In too many cases, women either don't seek care because they don't have the necessary funds.

The decades of 1970 and 1980 witnessed and the acknowledged that maternal mortality is a threat to the development of human life in the entire world. On many advanced countries maternal mortality figure and statical data on maternal health were beginning to average from an incremental trend in all the world data collection data centers on maternal health .WHO carried out maternal mortality data survey and censuses in the1970s to get the breakthrough of the solution to maternal mortality globally even although it was still hidden from the whole world body .it was unable to handle it.

Not until 1985 did the WHO with finical assistant from UNFPA to carry out the first ever maternal community studies program for the cause and the impact of maternal mortality and vis-a-vis the way forward. Through the collection of hospital data, vital and preventable neglect was found. A major finding was that ½ a million maternal deaths were taking place per year.

Developing countries or under developed countries like south Sudan occupied 99% of the mortality of the world statistic.

In 1987. Dr. Hafdan Mahler who was then the WHO Director General advocated that maternal health measures be given priority due to the appalling statistic within the result produced by the survey. He gave his recommendation to the world body to consider it in the first ever 1987 February joint WHO, UNFPA and World Bank launch of first international Safe Motherhood Conference in Nairobi. It's from such a back ground that Safe Motherhood was identified a cornerstone of public Health and henceforth, Safe Motherhood was placed on the world Agenda for Discussion to date.

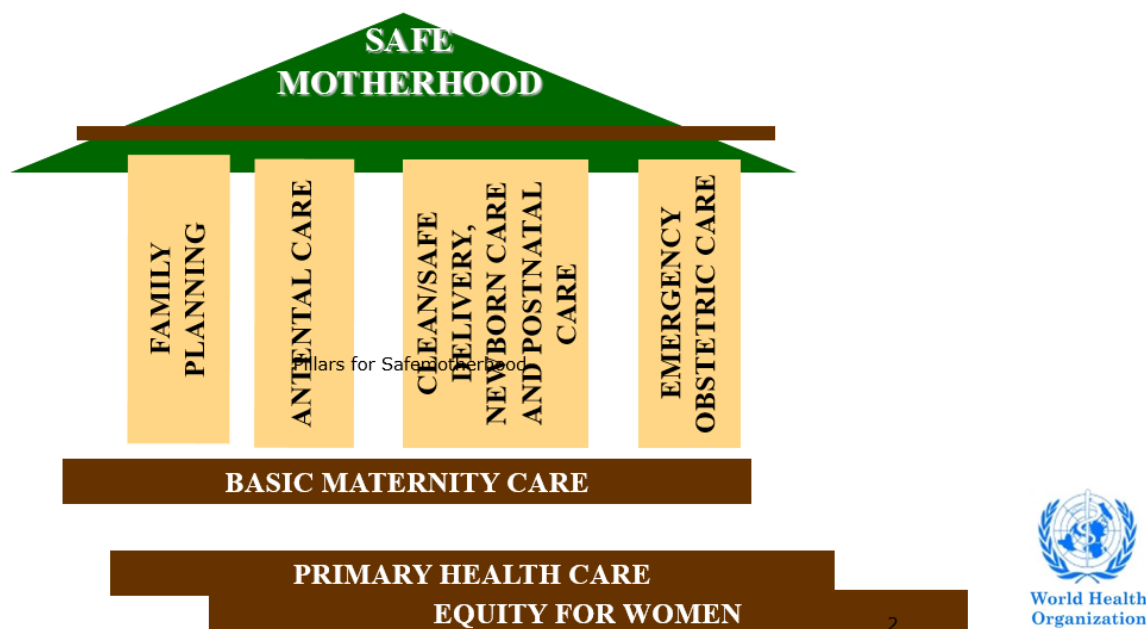
Safe Motherhood continued to be complex in nature as it's treated as a subset of other reproductive Health programs. Within children survival the fact that it is naturally, it was given limited economic recourses. Therefore such maternal mortality figure whether it's national, regional, and state blocks are urged to mobilize political will. And because of the rise of mortality in the world advances Advocacy, collective responsibility must press for the promotion of Safe Motherhood ⁴and the funding of staff in the form Obstetricians and gynecologists human Resource specialist as well as Safe Motherhood medical equipment.

It is estimated that by 1900 USA maternal mortality figures were 700/100,000 life birth but eventually this figure declined to 10 maternal death per 100,000 birth due to promotion of safe motherhood in USA Health systems 1990.

According to the WHO fact sheet on Safe Motherhood. The following if followed can reduce or even eradicate maternal mortality.

⁴ South Sudan: Desperate Struggle for health care in the world newest nation; ICRC News Release 12/138. <http://www.icrc.org/eng/resources/documents/news-release/2012/south-sudan-news-2012-07-06.htm>

Four Pillars of Safe Motherhood



Ante-natal Care

The world health organization (WHO) has recommended some few model Care package to achieve quality safe motherhood which WHO believed are economical and affordable by an individual or government Agency. This model includes 4 to 5 ante-natal visit to avoid maternal complication at the time or after pregnancy. This is simply to detect, prevent early danger signs of pregnancy related out come on both the baby and the mother.

- Routine blood pressure checking and measurement.
- Examination of urine for bacteria and protein examinations.
- Screening of the blood for Anemia and possible treatment for some abnormalities that may have impact on the pregnancy ranging from Tuberculosis, Hive, Malaria, Sexually related infection, Hookworms and subsequently advise on malnutrition signs and symptoms.

- Frequent high and weigh measurement at every visit.

The philosophy of such Ante-natal Care is simply to detect, prevent and prepare for birth through Health Education

Family Planning the ideal required quality of care

- ▶ Improvement of communication between the mother and midwives to avoid unintended pregnancy as the process of the case continues.
- ▶ Training of service providers to enhance technical skills and improve attitudes; as recommended by WHO 2010 to at list have skilled attendance instead of TBA
- ▶ Guaranteeing the availability of family planning commodities and supplies at all levels;
- ▶ Improvement of family planning logistics management (LMIS/HMIS);
- ▶ Enhancement of political and community support and participation in family planning activities at the Health systems
- ▶ Improvement of record keeping;
- ▶ Strengthening of the follow-up, supervision and referral systems.
- ▶ Increasing service points

Delivery care as a matter of quality

- ✚ Information on signs of labor, what to expect and what to do to be done by skilled attendant not TBA
- ✚ Monitoring labor and documenting for easier referral system
- ✚ Referral if it becomes necessary
- ✚ Clean supplies
- ✚ Drugs required for pain relief and delivery
- ✚ Communication with the family members especially the spouse

HIV testing and counseling

- ✚ Counselling on Infant feeding options

Post Natal care and newborn care as access requirement.

- ✚ Information on danger signs, what to expect and what to do is always done by experience midwives
- ✚ Immunization for both mother and baby
- ✚ Counselling on Infant feeding options
- ✚ Maternal wellbeing- nutrition, workload.
- ✚ Responsible fatherhood
- ✚ Family planning options
- ✚ Resumption of sex
- ✚ Post Natal Clinic at 6 weeks

Safe Motherhood reduce and detach maternal risk at prison PHC worldwide.

It's estimated that 1000-1500 mothers and newborn babies dies annually due to complication that can be easterly prevented through Safe Motherhood aspect of clean and safe delivery and post-natal care package therefore the WHO attributed skilled attendance package of Safe Motherhood can address all the above negativities.

The 1990 -2015 millennium Development Goals (5) was simply focused on provision of Safe Motherhood through training of more midwives and skilled birth attendants by 95% by 2015 which is also reflected in sustainable development goal number 3 as they provide the best care during and after birth as well as initiating breast feeding immediately after birth. And play a big role in the process of stopping and preventing of Mother- to child transmission of HIV Aids (PMTCT) on their ANC screening process.

It is estimated that 3 out of 10 health workers are trained or have acquired skills in safe motherhood; therefore, almost all PHCs lack specialized safe motherhood cadres in most health center institutions in developing countries. Therefore, the countries are called upon to redistribute and deploy and put attention on improving their status of Safe Motherhood.

The first dimension of the Continuum of Care is time - from pre-pregnancy, through pregnancy, child birth, and the early days and years of life (*Figure 1. Connecting care giving across the Continuum for maternal, newborn and child health*).



PIMCH (2011). Adapted from WHO (2005) - Make every mother and child count.

Full component of safe motherhood.

Pregnant mothers need full combination of safe motherhood package ranging from family planning, ANC, Clean and safe delivery and obstetric Care. As well as implementing drugs supply chain in the PHC and Hospital most cases this combination is not there as well as items.

⁵Leading to maternal death. E.g. another's health institution has delivery ward with no delivery bed and equipment installed inside.

Safe Motherhood data based storage.

It's usually very difficult to know how many women are enrolled for family planning the number of women attending ANC and numbers of birth using the birth rate and number of maternal mortality using MMR and the flow of the statistical data information from the Hospital, PHC, PHCU and government. Thus information is important for the Safe Motherhood policy development.

Many African Countries found it difficult to maintain quality safe motherhood due to complexities in implementing Safe Motherhood as they focused on training of midwives and gynecologists who lack specialized skill on Safe Motherhood hence this creates a health gap and continued maternal death becomes raised in African continent where resource are being earmarked for Safe Motherhood.

WHO focused advise on how to trained Safe Motherhood specialist among the midwives and gynecologist and improve strategic supply chain of Safe Motherhood commodity. And differential Reproductive health from safe motherhood in each countries strategic plan in order to reduce maternal death.

According to the WHO a quality and accessible safe motherhood should have the following as show in this table below.

⁵ [Child Survival Countdown to 2015](#), December 2005.

⁴ [Countdown to 2015 website](#)

⁵ [Tracking progress in Maternal, Newborn and Child Survival: Countdown to 2015- The 2008 Report](#)

⁶The Lancet: [The Countdown to 2015 Issue - April 2008](#)

Item	Number/percentage
Midwives	6 per Hospital 3 per PHC 2 per PHCU
Skilled attendance per 1000 per birth	Should be 95%
Family planning	Should be 75%
ANC	Should be 100%
Clean /safe delivery	Should be 80%
Post-natal / New born Care	Should be 100%
Obstetric Care	Should be 100%

(Source WHO 2002 health Report on Quality of Maternal Care)

It's estimated that the above if observed will minimize maternal mortality in each country.

Safe motherhood and Gender Related issues.

It is estimated that the majority of husband when it comes to maternity affairs do not understand pregnancy related complication. Hence due to gender difference dimensions (Elizabeth et al 2002). Men evade their responsibility when pregnancy is concerned. . Pregnancy is a very expensive venture in life right from conception to delivery money and care are required which made many men afraid. Safe Motherhood is associated with women more than the men. This explain why many countries like Uganda has initiated program of men attending ANC section to promote the involvement of men in Safe Motherhood. It is believed that for a quality and

accessible Safe motherhood (UNFPA 2014) 50,000 given population should have comprehensive Emergency Obstetric Care (CEMoNC) (WHO 2012).

According to Carlo Santarelli 2010 making pregnancy safe, the following are being focused on

- ✚ Advocacy to enlighten to the public the plight of the women.
- ✚ Technical support to all the countries on Safe Motherhood initiative.
- ✚ There is need to build partnership with other sectors
- ✚ Standard for maternal health should be set global as well as its norms to encourage development of tools for addressing maternal mortality.
- ✚ There must be extensive research an annual basis to established the really or exactly trend of maternal mortality.
- ✚ There should be an international global monitoring and evaluation mechanism established or put in place.

Women worldwide experience lower social status as well as Scio-economic status and legality in the society they lived in whether in prison or outside they suffer ,full of deprivation and oppression that create inequity with men I all aspect of life. Society acknowledge the deaths of a mother as a tragedy because it endanger the lives of children and the newborn both directly and indirectly.

Structural adjustment program effect on safe motherhood. (SAP)

According to de Brugn. Mutarika, 2003 the Structural Adjustment Program (SAP) do not perform well in African countries as it recorded health decline by 39% in African. As most African government were spending less money on drugs and well as privatization of health service. Safe Motherhood become expensive.

He” argued that one becomes pregnant freely without payment but in accessing pregnant service one has to pay for its unworthy life experience for women” this is reflected in the individual government charging user fees of the vulnerable women. This give poor attention to the achievement of objective of Safe Motherhood as many prefer going to traditional birth attendance TBA who deliver them free of charge. This explains why up to now 67% women deliver in the hands of TBA. Hence increasing the risk of maternal mortality because many TBAs are unskilled on using the Safe Motherhood equipment for prevention of maternal deaths.

The African Protocol on women stated that ,all state actors shall ensure that the negative effect of globalization and any adhere effective of the implementation of trade and economic policy and program are reduce to a minimum stage for a women. “The South Sudan reproductive policy 2012 prioritized safe motherhood as its major target due to the high maternal mortality of 2045/100,000 lives birth in south Sudan”.

Many sources suggested that for a Safe Motherhood indicator to fit human right standard in maternal health there are two most important aspects that affect health i.e. financial access and physical access. ⁶

Areas of interest that are a cause maternal death according to world health organization WHO 2004 are beyond numbers reviewing maternal death and complication to make pregnancy safer(<http://www.who.int/reproductove-health/publications/btn/text.pdf>).

- ✚ Absence of prenatal care
- ✚ Lack of support both social and economic during and after pregnancy
- ✚ And 3 Delay i.e. Delays from home in seeking health care
- ✚ Delay transportation and subsequently Delay at the health facility.

TBA (Traditional Birth Attendant) effort to preventable death

Allow me to use definition of a Uganda PhD scholar of what they met by TBA as it apply to my situation of research

"A traditional birth attendant (TBA), also known as a traditional midwife, community midwife or lay midwife, is a pregnancy and childbirth care provider. Traditional midwives provide basic health care, support and advice during and after pregnancy and childbirth, based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated. TBAs do not receive formal education and training in health care provision, and there are no specific professional requisites such as certification or licensure. They often learn their trade through apprenticeship or are self-taught; in many communities one of the criteria for being accepted as a TBA by clients is experience as a mother."(Dr Waiswa and Sandra Anderson2014).

Challenges faced by the TBA in quest for Safe Motherhood

⁶ Health Policy of the Government of Southern Sudan, 2006-2011 21

Have no knowledge of access of a mother or facility for detecting danger sign of pregnancy.

- ✚ Poor hospital or clinical environment related issues.
- ✚ Absence of gynecologist doctor to give a specialized treatment.
- ✚ Factor associated with wrong diagnosis due to poor medical history taken by a TBA from the sources of referral center led to wrong Administration of treatment and procedure of diagnosis.
- ✚ Poor drugs supply chain management that usual results to short of drugs and stocking of expired drugs in store.
- ✚ Inadequate advances skill that renders medical equipment with useless knowledge of how to use them by TBA.

Prenatal care it's most important package of safe motherhood as it involves use of pantograph. As such it estimated that 33% of maternal death occurs due to absence of prenatal care from pregnancy or child birth because as most mother lack economic support to hire care or just hiring of means of transport to the nearest hospital. Studies also revealed that separated women from their husband i.e. single, divorced and incarcerated. They are most likely to die due to pregnancy complication as they lack social support. Hence the study further revealed that the problem of accessibility is common problem in prison souring in developing countries.

Therefore quality and access are paramount if they are lacking in a population where pregnancy occurs strong advocacy must be immediately initiated to avoid maternal mortality as an aggravating a factor. Motherly friendly community is one that offer good transport and having qualified Nurse and well equipped maternity ward these leads to conclusion that Safe Motherhood involves quality and accessibility.

The study is carried out in one area i.e. the prison hence my study did not assert different observation on other PHC or Hospital or prison since it was only for Juba Main Prison (JMP) only it is inadequately reflection of all prison PHC though others prison PHC was been good or worse than Juba Main Prison PHC.

Tulisi Ram Bhandari (2014) PhD scholar. Global indicators on maternal mortality shows that the cause of maternal mortality are mainly as a result of Direct cause i.e. Hemorrhage 24% Eclampsia 12% unsafe abortion 13% obstructed labour 8% Sepsis 5% others direct cause 8% (ectopic pregnancy, embolism and anesthesia related cause.) while indirect cause account to 20% e.g. Anemia, TB, malaria, HIV/Aids etc. This study on the cause of maternal death is clear hence necessities investment into a full accessible and quality safe motherhood in all health institutions facility in a given country.

The Sustainable Development Goal (SDG) on safe motherhood. GOAL (3)

- ✚ It guarantee health life as well as promotion of all aspect of well-being of all citizen of all age regardless sex, young, old, colour and gender.
- ✚ 3.1 It provide for the all means possible for the reduction of the worldwide maternal mortality ratio to 70% per 100,000 live births.
- ✚ 3.2 2030 eradicate all the death of children both under 5 and newborn babies global by aiming to eliminating of mortality by 12 to 25 per 1000 live births.
- ✚ 3.7 2030 provision of sexual Health Reproductive services (SHRS) e.g. family planning, information and education as well as integration SHRS strategic plan and programs into maternal health (Safe Motherhood).
- ✚ Focusing on comprehensive coverage of the Health sector right from financial risk protection, Access to quality health Care as well as affordability of all supplies of medical equipment like drugs and medicine and vaccine for all cadres.
- ✚ 3. C prioritizing financing the Health sector, employment, as well capacity building and retention of the well trained health cadres in both developing and under developed countries as well world small islands.

Human rights tools

UN Standard Minimum Rules for the Treatment of Prisoners (article 23. 1, 2).

Stated that there shall be accommodation which is special for women in incarceration with women basic need requirement to meet their interest while in custody this include women with

children, and reproductive age that all sanitary facility is mandated to them. With space for Nursing infant for breast feeding mothers and a senior prison warden is to be assigned in charge of such facilities.

Article 12 of international convention on economic, social and cultural Rights ICESCR advocated for the highest physical and mental health to be attainable by all the state actor by availing all the steps necessary.

Furthermore Article 2 of the same convention also emphasized that the state party act on individual basis through the help of the international bodies as well as cooperation so as not to waste the state available limited resources in order to realize the rights in question. This aim at progressive attainable rights by each state as seen in this case below.

International Covenant on Civil and Political Rights, Article 24(2)

A child who is born in prison shall have right to be a issued birth certificate as well nationality without indicating that he or she is born incarceration.

Article 10(2a) any person who is accused shall be allowed to serve his or her sentence based on the circumstance of his/her conviction and subject to separate treatment based on his/ her status. Hence pregnancy women in custody deserve separate treatment to grantee their basic human rights.

Convention on the Elimination of All Forms of Discrimination against Women, Article 12 (2)

With According to Article 12 paragraph 1 of this statute all state parties are asked to provide women adequate service when it come issues related to pregnancy, confinement and care after birth of child (post-natal care). Hence women are required to be given free food that is an adequate diet .in terms of its nutritional values and especially for pregnant women

Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Principle 5 (2):

All steps shall be applied in accordance with the laws that are designed solely for the right to protection. In addition to special protection for women e.g. pregnancy women and those who are breast feeding infant. Children (juveniles) the old vulnerable sick disabled shall not be discriminated against hence the need in such circumstance are pardoners to be reviewed by law at any given time or period of time by the authority⁷

Human Rights Committee, General Comment 28 on the equality of rights between men and women 123

Women who are pregnant shall not be denied their personal liberty. Therefore shall they be accorded a full humane treatment, honors for their dignity as much as it put in the constitutional rights and international acknowledge especial during birth and during pregnant when caring for the infant child. All state parties should set facilities that are necessary and adequate in terms of the obligation for such obligation on medical health to provider for both the mother and the baby.

Sixth UN Congress on the Prevention of Crime and the Treatment of Offenders, Resolution 9, Specific needs of women prisoners 124.

It should be understood that women always have 80% of their daily activities and responsibilities for children's care. Therefore deinstitutionalization of such a mother from her home state amounts to complete disposition of woman both psychological from her family and cause a great trauma. Therefore the UN and its NGO Partners recommended that the imposition of an alternative sentence shall be considered when sentencing a mother e.g. sentences in such community service are the most appropriate for them. Even during arrest, trial, sentence and imprisonment women who are pregnant shall be treated with fairness and equality because they encounter many problem in in their condition.

8th UN Congress on the Prevention of Crime and the Treatment of Offenders, Resolution 19 "Management of criminal justice and development of sentencing policies"

⁷ 127. See *Offenders and Victims*, *supra* note 1, at 4.

128. Universal Declaration of Human Rights, *supra* note **101**, art. 2.

129. Covenant on Civil and Political Rights, *supra* note 110, at pt. II, art. 3.

130. Convention on the Elimination of All Forms of Discrimination Against Women,

Imprisonment..... As a tool of sentencing recommended that should be imposed on certain group of people/persons e.g. pregnant women or mother with infants because imprisonment in such categories is act of sanction and it not be allowed to degenerate into a double sentencing that cause more mental trauma to the victims.

Health status the General Committee 14 (3) of the economic, social and cultural Rights emphasized the importance of Health Rights. Therefore it embedded the following Rights

The Rights to control ones health and body. The Rights to sexual and reproductive health.

The Rights to freedom of choice of quality and good family planning.

General committee 14 (4) Elaborates on the requirement that government provide for the reduction of the still birth rate and infant mortality and for the Health development of the state.

Besides the international instruments cited above, which constitute the basis of the right to health, several regional and international conventions and treaties recognize this right. Following are the main ones. Some of these include:

- The 1965 International Convention on the Elimination of All Forms of Racial Discrimination (Not Ratified by South Sudan);
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Not Ratified by South Sudan);
- The 1984 Convention against Torture, and other Cruel and Inhuman or Degrading Treatment or Punishment (Not Ratified by South Sudan);⁸
- The 1989 Convention on the Rights of the Child Not Ratified by South Sudan);
- The 1990 International Convention on the Protection of the Rights of All; Migrant Workers and Members of Their Families (Not Ratified by South Sudan);
- The 2006 Convention on the Rights of Persons with Disabilities(not ratified by South Sudan);

⁸ Jenni Gainsborough, Women in Prison: International Problems and Human Rights Based Approaches to

Reform, 14 Wm. & Mary J. Women & L. 271 (2008), <http://scholarship.law.wm.edu/wmjowl/>

vol14/iss2/5

- The 1981 African Charter on Human and People's Rights (Not ratified by South Sudan);
- The 1990 African Charter on the Rights and Welfare of the Child (Not Ratified by South Sudan).

Article 2 of the United Nations Declaration on the Elimination of Violence against Women stated that violence against women shall be understood to encompass , but not be limited to the following(.....)

(C) Physical sexual and psychological violence perpetrated or condoned by the state, wherever it occurs being in prison or outside it shall not be tolerated.

Article 4 states that states shall not tolerate violence against women in any form hence should not invoke custom, tradition or religious consideration to avoid their obligation with respect to its elimination. Therefore states should pursue by all means possible to mean and without delay a policy that shall eliminate violence against women.

(i) Should take all measures that law enforcement officers and the public officials are implementing policies to prevent, investigate and punish violence against women receiving correctional service.

Article 11 of the Convention against torture and other cruel, inhuman or degrading treatments or punishment. All states party to make sure that system review interrogate all rules, instruction, method and practice as one of the arrangements for the custody and treatment of prisoners or imprisonment in any land under its jurisdiction to prevent torture.

The United Nations Standard Minimum Rules for the Treatment of Prisoners article 8 stated that prisoners be kept differently and separately in their institutions taking into consideration the dynamics of their sex age criminal record as well as the legal reasons of their detentions as follows;

Men and women shall be detained separately in their institutions, young inmates shall be kept separate from adults and in case of an institution that is set for both men and women like a hospital there must be partition to separate men and women seeking service.

The intuitions set for women should be under the responsibility of women officer who shall have the custody of the keys of all the parts of the institutions. And therefore no men is allowed to enter into such facilities unless in the company of a woman officer. Women prisoner shall be attended and supervised only by women officer however this does not preclude the male members of the staff's professional body like doctors and teacher from doing their professional jobs.

The united nation human rights committee, general comment article 17 of the international covenant on civil and political rights guarantee all persons rights to privacy.as well as the human rights committee general comment 16 on the article 17 stated that, so far as personal and body search is concerned there must be effective measure taken to ensure that such a search are carried out in lawful manner consideration personal dignity.

Under the united nation standard minimum rules for the treatment of prisoner's rule 33 indicate that instrument of restraint such as handcuff, chains, irons and strait-jacket shall not be used as a punishment. And shall not be used as restrained subjects unless in such circumstances of escape during transfer and be remove after prisoner appear before a judicial or administration authority.

The united nation standard minimum rule for the treatment of prisoners rule 27 enforcing discipline and order shall be maintained with firmness but with no more restriction than is necessary for the safe custody and well –order community life but with due consideration of pregnant inmates.

Rule 31 all to do with corporal punishment by placing in a dark cell all cruel, inhuman or degrading kind of treatment are completely prohibited as well Rule 32 punishment by closed confinement of reduction of diet shall never be encourage unless on medical backgrounds.

The basic principle for the treatment of prisoner principle 9 stated that all prisoner shall have access to the health services available in the country without discrimination on the basses of sex or legal situation.

Principle 24 maximum medical examination shall be offered to the detained or imprisoned person as promptly as possible and whenever needed.

The United nation convention against all forms of discrimination against women article 12 state that all sate shall take measures to eliminate discrimination against women in the field of health care for basic access to health care services. Including these related to family planning.

The United Nations Standard Minimum Rules for the Treatment of Prisoners 24 all medical officers shall see and examine every prisoner equally in order to ascertain their health risk while in prison. This must be done by a professional medical doctor.

Medical screening on entry is very important that as soon as a prisoner arrives at the prison he/she has to undergo medical examination and health screening on an individual basis as to ascertain the following to ensure that the prisoner is healthy, and identify any sign of illness that may appear while in custody.

The United Nations Standard Minimum Rules for the Treatment of Prisoners rule 15 advocates for clean and water which is necessary for the health of any inmates.

The European Prison Rules 2006 emphasize provision of sanitary needs to the women one in incarceration.

Article 10 of the International Convention on Economic, Social and Cultural Rights states that especially protection be given to mother during a reasonable period before and after child birth in order.

United Nations Convention against all forms of discrimination against women (article 12). Notwithstanding the provision of this paragraph I of this article, clearly stated that all parties shall ensure that women are given appropriate service in connection with pregnancy, confinement and the post-natal period granting free service.

The body of principle for the protection of all persons under any form of detention or imprisonment principle 5 (2) as required by law rights and special status of women especially pregnant women and nursing mothers, children and juvenile aged, sick or handicapped person shall not be deemed to be discriminatory[...]

Rule 23 (1) of the United Nations Standard Minimum Rules for the Treatment of Prisoners women institution shall be special for all necessary pre-natal and post-natal care and treatment. And arrangement shall be done for women to deliver at the prison.

(2) If there are nursing mothers the infant be allowed to remain in the institution with their mothers and there must be provision for such categories of people in prison.

The General Comment 28, the Human Rights Committee stated that pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at

all time especially during and after birth and while caring for their newborn children and required states parties to reports on facilities and medical and health care for imprisoned mothers and babies. This further accepted by the council of European parliamentary assembly recommendation 1469 (2000), on mothers and babies in prison adopted on June 2000. In the view of the adverse effect of imprisonment of mothers pregnant and with babies the assembly recommends that the committee of ministers invite member states to develop and use community-based penalties for mothers of young children and pregnant to avoid use of prison

ii. To develop education programs for criminal justice professionals on the issue of mothers and young children, using the United Nations Convention on the Rights of the Child and the European Convention on Human Rights;

iii. To recognize that custody for pregnant women and mothers of young children should only ever be used as a last resort for those women convicted of the most serious offences and who represent a danger to the community;

iv. To develop small scale secure and semi-secure units with social services support for the small number of mothers who do require such custody, where children can be cared for in a child friendly environment and where the best interests of the child will be paramount, whilst guaranteeing

Public security;

V. to ensure that fathers have more flexible visiting rights so that the child may spend a little time

With its parents;

vi. To ensure that staff have appropriate training in child care;

vii. To develop appropriate guidelines for courts whereby they would only consider custodial sentences

For pregnant women and nursing mothers when the offence was serious and violent

And the woman represented a continuing danger.

viii. To report back on the progress made by the year 2005.

Pregnant women and women with young children should not be imprisoned unless

Absolutely necessary. Appropriate legislation should be in place and sentencing guidelines

For courts should underline this principle. If they are imprisoned, the State takes

On the responsibility to provide adequate care for the women and their babies.

Constitution and legal issues

South Sudan transition constitution (SSTC)

Public Health Care

Article 31. All levels of government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.

Right of Rights of Women

ART16. (1) Women shall be accorded full and equal dignity of the person with men.

 Constitution is a sources of harmony and reorganising of such culture.

► South Sudan Prison ACT 2008

65. Female Prisoners and their Children.

(1) Where practicable, female prisoners who are pregnant shall be taken to deliver their babies in hospitals and if a child is born in a prison institution, every effort shall be made to secure the assistance of a mid-wife or traditional birth attendant and no mention of the same shall be made in any registry.

(2) A baby born in a prison institution has a right to be suckled and cared for by his or her mother for two years.

► (2) A baby born in a prison institution has a right to be suckled and cared for by his or her mother for two years.

(3) The Prisons Service shall be responsible for food, clothing, health care and facilities for the sound development of any child for the period such child remains in a prison institution with his or her mother.

► (4) After the age of two, the child shall be handed over to the person who is responsible for the child according to law, unless the Prison Director allows the child to remain in the prison institution on reasonable grounds, including if—

(a) a medical officer considers it is in the best interests of the child's physical or mental health to remain with his or her mother; or

(b) the child has no near relatives.

(5) The regulations shall provide for the conditions in which a child may remain in a prison institution, including obtaining a birth certificate when the child is born in the prison institution.

► **68. Health and Medical Care.**

(1) A prisoner shall be entitled to adequate health care services based on the principles of primary health care.

(2) The regulations shall provide for other requirements, including referral of prisoners to medical facilities and examinations outside the prison institution

77. Prisoner Rights.

Every prisoner shall have the right to—

(a) adequate and nourishing food and clean drinking water;

(b) regular and adequate medical care;

(c) privacy;

(d) adequate clothing;

(e) bedding;

(f) keep personal effects;

(g) basic sanitation;

(h) education, vocational training and reading materials;

(i) all necessary individual assistance that is required in view of a prisoner's age, sex and personality;

(j) regular recreation and exercise;

- The south Sudan national policy article 21 states that all effort shall be put improve maternal health in all sectors especially that of reproductive health and safe motherhood to meet MGD NUMBER 4

CHAPTER THREE

RESEARCH METHODOLOGIES AND METHODS

Grounded Theory

Safe motherhood is the most challenging condition that women face when in prison as most of their movement are curtailed by confinement in prison. Hence access to the Safe Motherhood package become problematic. Especially incarceration with pregnancy is made very complex for them. Therefore for reliability of the assumptions grounded theory become a part of my research investigative tool. Grounded theory influenced my data collection methodology through adjusting my assumptions, corroboration and data collection. This was done by my visit to the Prison, Prison PHC and NGO that are operating within the prison in offering service.

Therefore my theoretical assumption started changing, especially the one that stated that there is no accessible to Safe Motherhood have to be immediately adjusted and my definition of accessibility had to change because having delivery ward without a bed does not signify that it is an accessibility problem. Therefore even the presence of health work means the presence of Safe Motherhood personnel, though they later turn out to be TBA staff and not real midwives trained to handle Safe Motherhood.

Examination of both the delivery ward and the ANC ward where pregnant inmates are attending ANC and delivery. Used a check list approved by WHO office in South Sudan to assess the standard of quality and rights definition of access according to WHO and UNFPA. And World Bank e.g. the equipment at the facility, the staffs i.e. the Nurses and ANC and birth register and how records are kept were used. This involved interviews with the head and various heads of the departments at the prison PHC.

(These interviews were conducted with the inmates, who were pregnant, other inmates who had given birth and were still at the prison and an inmate who had given birth and out of the prison, prison wardens in charge of female wards, prison wardens in charge of prison PHC were also in attendance).

This methodology was evidence based as women who were from the prison were able to tell their problem vis-visa how if possible the government intervention should be directed toward the issues in question for proper address. The prison health workers were also interviewed in order to capture their views on the issue in question

Never the less the research was able to uncover the grounded difficulties faced by the staff ranging from poor funding, ill-training and excessive bureaucracy that existed at the institution, both the Ministry of Health and the prison bureaucracy. Could be deal with however in the first two month it was difficult to follow female inmate who are taken for birth delivery to Juba Main Hospital as it took long for me to be cleared by the ministry of health Research department GOSS. Women's voice speaks through my research and could immediately address the problems they were facing as well as the prison health workers. This expectation alone made me respond to some of the needs that were facing especially the pregnant mothers we supplied them with the Mama Kit from Reproductive Health Association of South Sudan (RHASS)

However in the beginning it was difficult to get information from the PHC staffs especially the statistics and the register and other records as they were not well organize. Two female inmates who were pregnant but because they were from especially economical educated, employed class and know their women's human rights were given different treatment. All services they were given including being escorted out for ANC in a Private Hospital like Juba Complex Medical Care Center were given spontaneously which was a surprise for me. The impression I got is that if all female inmates were educated like these two I think Safe Motherhood Service would be improved because these women shall push the government to provide for them, where as they are paying the cost of illiteracy by not knowing their rights as women. Hence they suffer from lack of always pads and etc. What also emerged was the loss security of the inmates at the court as they were seen being attacked by their own complainants. After conviction as they were waiting for transportation to the Main Prison as such Two inmates were attacked by their complainant at the court premise.as a result they suffer miscarriages and the attacker escaped without being arrested by the court police. Better at all level will used to be introduced.

Human Rights Based Approach.

Safe Motherhood (maternal health) is a human rights issue enshrined in various international treaties and as well as instruments to which South Sudan as a new country is made to become member of all these treaties as a world member a state member and African number 54 state. As women's human rights activities it was important to examine women's human rights aspect in this research, given South Sudan worst human right record always reported by UN bodies in all humanitarian and conflict reports in South Sudan the UN need to examine the following Rights as they apply to the citizen of South Sudan

- ✚ Right to maternal health care.
- ✚ Right to health
- ✚ Right to life

It was now imperative to find out whether the prison official knew something about the human rights of the female inmates in Juba Main Prison and the negative human rights reports on South Sudan in general as well as to respect these rights in the prison. The UN has proposed for South Sudan a transitional constitution and international human rights bodies. However it turns out that the right of these inmates the officials who are aware of basic fundament human rights of this inmates. explains why the South Sudan Juba Prison Female Inmate Prison is operating like a semi open prison where inmates move around the compound cook for themselves the types of food they can afford and wish to eat while incarceration. Therefore South Sudan is totally not incompliant with the international law that applies to all. observation was that female inmates knew about their human rights, but they lack mechanism of advocacy to raise their voices up for recognition while in prison.it was very important to examine whether the ministry was following the 1987 Safe Motherhoods objective and managed to achieve an indicator for MDG 5 during it is implementation period and vis-visa the new and SDG 3 for 2030 how achievement would be given the previous experience in conflict South Sudan the Ministry of Health to evolve new strategy and policy, strategy plan. Like multi sector approach that was adopted by Rwanda after the 1994 Rwandan war.

Interviews were also carried out by South Sudan Red Cross (SSRC) state coordinator and the health department as NGO handling health rights in prisons. Aids Resistant Trust (ART).

All those interviews were to find out informing these female inmates about their maternal rights as well promoting these maternal health rights at the prison. However, research observation indicates that this NGO lacks monitoring and Evaluation mechanisms as it was witnessed by South Sudan Red Cross SSRC donated delivery bed in 2014 even now the bed has not been assembled as they lack technical staff and tools for their assembly. Organization was interviewed and acknowledged the donation South Sudan acknowledge donation of the delivery bed by an Italian assistant to South Sudan in 2014 but that project ended and as a result as a result there is no fund for monitoring and evaluating the projects life cycle. Now that is a year has passed.

The Women's Law Approach (WLA)

In particular it is used to uncover a reality and evidence based Result Oriented Approach (ROA) looking at which law do they apply those of Sudan or South Sudan? This allowed me to go to the field and get for myself further details of this lived reality.

The importance of this approach it is to inform and analyses the real experiences of the pregnant women and lives at the prison and issues pertaining their lives and treatment in incarceration.

It was difficult to unearth the lived reality because in South Sudan things on paper look very comprehensive including the constitution that gave women 35% representation in all levels of institution but is this real? That challenged my understanding. Therefore to clearly observe women rights in the prison one has to look at the difference between the ways in which men and women are treated under the male dominated legislature of South Sudan. Seen through women's eyes we need to assemble their context of the situation.

“Women's law knows no formal limitation other than the Feminist perspective..... No legal issues, in theory, is without relevance for women's law before it is been examined (Stang Dahl 1987.)

Therefore through the voice collection of the female inmates and prison staff I was able to gauge the accessibility and quality of Safe Motherhood in Juba Main Prison. And the nature of the referral system in place, whether according to the prison act of 2008 or not and reveal the lived reality on the ground. Pregnancy is very complex in nature for women because being pregnant

and incarcerated means one being in prison twice given the hardship involved in access Safe Motherhood package like ANC family planning, clean and safe delivery and comprehensive Obstetric care as well as post-natal care while in prison. One would to image if labour pain begun in prison where there is no Mama kit, no flowing water, no money, no clothing for the child, no pieces of soap no stand by ambulance to support a referral system to Juba main Hospital. Hence the whole situation becoming life threatening and night mare.

WHY approach

This helped me to investigate issues in detail so that I could engage the leaders on why, why and why some things are not happening given that the law on paper is very clear black and white It helped me identify where the gap is in my research. Example given the main prison has a functional PHC and a delivery ward and ANC ward why is not equipped with the required equipment, the explanation was lack of funds why lack of fund, because fund are not allocated in the budget by finance why finance don't allocated fund because the priority is security not health.

And my why continue without end. I was able to understand where the problem lays. Thinking systemically: this is when I encounter an unexpected reason from the prison authority of why some of this safe motherhood are not in place despite all government effort in place. Therefore I have to thinks about process that enable the poor quality at the prison through looking at the whole situation of the Health fraternity in South Sudan and relationship with the UN agencies in South Sudan through assessing the currently reality and why it is so .

By balancing advocacy with inquires of the whole circumstance as well creating a shared solution to lack of safe motherhood at prison PHC.

The deliberated nature of Subjects

It should be noticed that I have had to used Safe Motherhood is check list approved by WHO South Sudan office to assess the quality of the safe motherhood package e.g. quality of family planning, ANC birth delivery and post-natal care. Therefore the answers "Yes or No "must be reached through deliberation. And allow the answers to our question to explain the issues using

their own language and translated to the researcher in simple Arabic you known South Sudan has 64 different ethnic tribe with huge language diversity. Hence this give opportunity for every female inmate to express herself freely without fear and echo her own prison experience. Being able to record every individual suggestion allows us to improve the whole situation in the prison as the first hand beneficiary of the service in this particular prison.

Sample size and Area of study

This research was carried in Juba Main Prison South Sudan in Juba county central equatorial state with the female inmates both pregnant and those who have given birth at the prison facility or those who have visited the Juba Main Prison PHC for ANC. Therefore I believed that this sample size is very representative in nature and gives valid information on quality and access to Safe Motherhood. I welcomed the objective because I had reached a stage .where the some data was being communicated out by my own respondent. And so concluded that more investigation was distorting the real concept of the research.my sample information were 77 in number from the different group I interviewed, inmates, health workers, nurse and NGO.

NO	CATEGORY/GROUP	RESPONDENT DETAIL	NO_MALE	NO_FEMALE
1	PRISON GROUPS	<ul style="list-style-type: none"> • Pregnant women • Mothers • Youths not given birth • Women with pregnant complication 		14 11 8 2
2	Prison heads both health worker and non-health worker	<ul style="list-style-type: none"> • Head of PHC • Midwives • TBA 	2	6 4
3	NGO STAFFS	SSRC ART RHASS	4 3	1 2 2
4	GOVERNMENT OFFICIAL	HEAD female prison Ministry of health Prison wards	5 14	2
			25 MALES	52 FEMALES
	TOTAL RESPONDENCE		77 PEOPLE INTERVIEWED	

Tool one.

Structured questionnaire was developed to obtain data from the pregnant women who had attended the Safe Motherhood package at Juba Main Prison two or more times. This was meant to collect data from the pregnant women about how access and quality were present in the way that they were treated in terms of care services.

Tool two. A focus group discussion guide was developed and used to collect data from the FG. Participants in the FGD were inmates, health workers and their perception of quality of care was sought.

Tool Three.

An interview guide was developed and used together with a tape recorder in the in – depth interviews. This was meant to find out from the interviewees about their opinion and what they felt were the facility’s weaknesses and strengths and the possible solutions for the weaknesses.

Tool Four.

A check list from the scoring sheet for the yellow star assessment review was used to make observations. This was used to complete the basic list ideal necessities required in the execution of Safe Motherhood and tested the necessities that were available.

Research Methods

Interviews

One on one interviews were carried out eventually after long struggle with the prison authority due their fear that the female inmates would expose their weaknesses and subsequently there political effect on the authorities at the prison. It was regarding the quality and accessibility of Safe Motherhood to the female inmates at Juba Main Prison and Juba Main Hospital.

Observations.

Many observations were made as I went through the PHC and the Hospital to see whether both quality and access were available there for the female inmates in Juba Prison .and observing many things that they could not tell me during interview e.g. I was able to observe that there was discrimination in treating female inmate among the women themselves. I assessed delivery from the flow of mothers in the ward. I also observed Manual ANC being done by the prison TBAs. The free movement of female inmate was also observed within the prison fence.

CHAPTER FOUR

FINDINGS, DISCUSSION AND ANALYSES

Introduction

In this research the following comprehensive package of safe motherhood is being looked into:-

- ✚ Family planning access and quality
- ✚ Ante-natal care access and quality
- ✚ Clean and safe delivery and postnatal care access and quality for the prison inmate
- ✚ Quality of comprehensive obstetric newborn care (CEMoNC) offered to the inmate at Juba Main Prison.
- ✚ Why the government is failing to comply
- ✚ Juba prison PHC clinic
- ✚ Juba main hospital maternity clinic
- ✚ Government responses
- ✚ Ministry of Health
- ✚ Nurses and equipment
- ✚ Prison level responses

South Sudan maternal mortality is 2045/100,000 live birth according to WHO 2014. Hence these indicators alone made me to think that in my research assumption I need to say that there are no safe motherhood facilities in South Sudan health institution. I present why such high figure are coming up?. Because most literature from UNFP, WHO on South Sudan maternal health are not accurate. Hence if the Safe Motherhood Facility are there and functioning well then the access and the quality need to be investigated. (http://www.cmmb.org/wp-content/uploads/2014/09/Juma-CCIH_Combining-Tradition-Technology-Safe-Motherhood-2014-06.do...)

Therefore Juba Main Prison since the colonial era not much has changed at the PHC to improve its Safe Motherhood status. As a result the referral system is still to Juba Main Hospital which is a few kilometers from the prison .Therefore as a national main prison Juba Main Prison PHC is supposed to be more of satellite PHC as many female inmates around South Sudan can be incarcerated shall have a full qualified Gynecologist and midwives as well as nurse too.

The female inmates are draw in from the following categories those who are incarcerated when pregnant, other in the process of getting Bail and then becoming pregnant from home. The prison is estimated to host less than 50 inmates but due to shortage of accommodation it accommodate more than that estimated number to tune of 177 inmates.

.

Family planning access and quality

There was no improvement of communication between the prisoner and prison warder to avoid unintended pregnancy as the process of their cases continues. The observation is that the maternity ward, the walls are very clear without any writing on them there ought to be posted on the wall stressing on the negative or positive signs of family planning so as to inform the female inmate on how to manage their lives and when and all this had to be done in both Arabic and English.to initiate behavioral change communication (BCC) among the female inmates.

Training of service providers to enhance technical skills and improve attitudes; need to be improved as recommended by WHO to at list to a skilled attendant instead of TBA. Juba main Prison health worker especial those who works at the maternity ward are unskilled, most are TBAs. Therefore availability of skilled delivery is a signal of Safe Motherhood worldwide and skilled attendant has have a significant effect on improving safe motherhood not only in south Sudan but also global. This is because skilled attendant is a factor in achieving MGD 5

Guaranteeing the availability of family planning commodities and supplies at all levels of the PHC is imperative. It should be noticed that the Juba Main Prison has no supply chain management system in place to monitor inflow and out flow of all contraceptive of all kind up to the time of compiling this report even desk or a box is available for handling family planning

case moreover the institution is for women of reproductive age and none reproductive age as well. Improvement of family planning logistics management (LMIS/HMIS) is paramount for such functioning institution that handle more than 50 women on monthly basis.

Enhancement of political and community support and participation in family planning activities at prison need to be improve. It was not there as a result political leaders do visit the female prison but only to observe its condition feeding facilities, hygiene, and accommodation only leaving a life- threatening technical issues unaddressed.

Improvement of record keeping; there was no register showing the names, of women inmates on family planning or even removed from the prison . furthermore, it is estimated that due to the than Marri-stop international NGO present in South Sudan ¼ of women are enrolled in either one or more type of family planning in their life time.

We now need to improve the follow-up, supervision and referral systems especial those female inmate who family planning is due for removal and because the PHC is ill equipped and was lacking. Anything else's would expose women to the danger of having expired contraceptive in their body that alone could cause more complication to them. Increasing service points some of the in access issues on family planning at Juba Main Prison

“I am in trouble lam seeing my monthly period every 11th of a month but I don't have pad to help myself with, if my relative brings for me lam lack if not I sufer.so l better insert jadal to free from all this, imagine when lam on my period I don't go I stay inside for a week. Bearing all the pain”. NB there are women who go to the prison with inserted family planning they face problem of who to remove and when and where?

Ante-natal care access and quality

Information, education and communication on risk factors and warning signs and symptoms during pregnancy and no adequate provision has been made for them. Hence this exposed the female inmate the danger of complication during and after birth. Information during ANC helps prepare the mother both physically and mental for pregnancy. It is a very complicated event. It was very amazing to see when a pregnant female inmate who was in prison for 3 months refused to tell the prison authority that she was pregnant. It was during the compiling of this report during FGD that she said she was pregnant. Hence she thought as any outsider I could offer her a

good an package. Compared to the prison manual ANC at the prison. Which she was not willing to attend to.

Prevention and management of anemia is not provided for. Moreover anemia is the main killer in pregnancy (WHO 2014).Therefore due proper feeding system was not set in place in the prison because of the micronutrient deficiencies appear in a diet as most inmates are fed on beans and posho only with no substantial diet given them.

Therefore the anemia increase risk of complication may recut causing death of maternal complications like low birth weight, hemorrhage, sepsis, stillbirth. Provision of iron and folic acid supplements to the women is done at the main hospital on referral basis when there are cases of complication. Therefore this single lack of competence among the prison PHC health staffs occurs because if any inmates is not developed complication she shall not be attended to yet these compliment any diets are basic for a normal development of fetus.

Screening for hypertension and diabetes is not being carried at the prison PHC as well as Examination of the mother to evaluate her pregnancy as these test and examination help in early detection and management or referral of mothers with high risk pregnancies. Everything is manually done such that most threatening risks are not detected early hence, exposing female inmate to risk of maternal death.

Immunization against tetanus; was done on a quarterly base as required by South Sudan national health policy 2014 as well as Syphilis screening and treatment, thus exposing the unborn baby to risk of infection. (WHO 2014) estimated 500,000 cases of occurrences of congenital syphilis annual global rate therefore testing is part of the prevention of syphilis at any given antenatal care facilities and can be treated with penicillin before the 16 weeks of any gestation

HIV information, testing, treatment and referral; this was carried out by NGOS. ARVs for prevention of mother-to-child transmission of HIV yes given by NGO. However the PHC has no testing reagent hence exposing to risk not only to the TBAS but also to the female pregnant inmate whom risk passing on infection to the child during birth. As such HIV pregnant women are always expected to be attended by a high level health professional given their situation to avoid infecting the baby as well as the health worker. One TBA admitted being in risk given that

they were told in workshop about the danger but it was unfortunate that such service are missing hence exposing them into a risk.

Prevention and management of malaria; this is done but there was a complaint from the women of fixed choice. Malaria speeds up the rate and the risk of maternal anemia hence subsequently these result in a low birth weight of a child, premature birth delivery (miscarriages). Therefore they constitute high risk of infant mortality. However malaria is treatable by means of anti-malaria drugs. It can be prevented through the use of insecticide treated beds and nets. Despite few mosquito net used by some of the few inmates at Juba Prison lack regular spraying of their nets and rooms resulting in cases of malaria case.

Birth preparedness mechanism were not carried out .Such mechanism of birth preparedness enable a mother to be ready to face the birth of the fetus she is carrying for nine months. This involved procurement of a mama Kit, clothing, looking for child name, where and how to give birth, saving money because in the few months she may be weakened and full of pain to perform any economic activities for generating an income to support herself, need to look to same one to support her in that time. Thus some birth provide preparedness package as guarantee of Safe Motherhood to a pregnant mother. However the finding found out that at the prison a women after birth she shall be assigned two senior inmate to take care of her for two weeks immediately after birth.

“It was from here that female inmate in FGD was shedding tear. When asked what was the problem? She said, she is imaging how her situation shall be if her time comes to delivery am having nothings with me only me and my God”. Therefore one can see how bad the situation is to be in prison and pregnant.

Male involvement .there is supposed to be male involvement both moral and economical support to the pregnant woman but these is not the case at prison because men are allowed to enter during visiting hours which is not enough to comfort such a traumatized mother that need plenty of care and counselling on Nutrition and Infant feeding regarding counselling and changes that may occur immediately after birth.eg change of homonyms within 24 hours after delivery.

Clean and safe delivery and postnatal care access and quality for the prison inmate

Information on signs of labor, what to expect and what to do was done by TBA at the PHC but there was no delivery form record or check list to use for the following of the delivery process e.g. one of the prison TBA explained the following

“We only able to observe the following uncontrollable urges to push a baby, holding her breath, coming out of sweat, and frequent change of her mood and anus begin to bulge due contraction and many others”.

This explains due referral the TBA has no delivery birth history recorded for the gynecologist to follow hence she has to explain the whole process to get the history of when, what time how all this is necessitates need new procedure. Hence it is worst of all if a delivering mother is unconscious cannot explain exactly what might cause to her prolong labour. Hence, this exposes the mother to danger. Monitoring labor and documenting that it has done properly important. It might otherwise become a problem when it comes to referral.

Referral if it becomes necessary.

It's only when this data collection compilation process stated, that when mother no long deliver at the prison PHC hence all case of birth delivering are now being referred to Juba Main Hospital. The question here is the sustainability of such process given the south Sudan economic crisis some time where there is no fuel in the capital city for cars

Clean supplies and Drugs required for pain relief and deliver are given but where there is a shortage the inmates relatives would have to buy medication from Private clinic and communication with the family members especially the spouse are usually made to alert them. HIV testing and counseling are not done at the PHC hence it's still remains a challenge to be addressed as well as Counselling on Infant feeding options

Post Natal care and newborn care.

The flowing important aspect were found lacking quality by the time of collecting this data

- Information on danger signs, what to expect and what to do is always done by an experienced prisoner helping her fellow woman. Therefore it lack quality as it was given by an unskilled person.

- ▶ Immunization for both mother and baby are done quarterly. Immunization builds the immune system of the expectant mother as well as protects the unborn baby from other infection that may result from complication during and after births.
- ▶ Counselling on Infant feeding options is not done. It is very necessary aspect because it prepare the mothers mind on how to handle the pregnancy and how to be accepted on some of these changes brought about by pregnancy. It also builds confidence on the part of the mother. Despite all that she is going through that there is hope for her health.
- ▶ Maternal wellbeing- Nutrition, workload is on individual bases. nutrition for pregnant mother need to be up dated with all the balance diet need ranging from vitamin A to vitamin B and C and other important food nutria for the development of the fetus any lack of such a value of food in a mother shall result in malformation of the child in the womb.
- ▶ Responsible fatherhood is absent. Fathers are known for the psychological support that they give to their spouse. But isolation of such mothers from spouse causes mental trauma and this affects the mental balance of the body.
- ▶ Family planning options are not provided. Most country suffer from unmet need of family planning. Women are not given adequate choice to select what kind of family planning is best suitable for them to avoid untended pregnancy. Women in prison are just left on Gods mercy hence they end up getting pregnant as they battle their case procedure in and out of courts.
- ▶ Resumption of sex education is not provided. Most women after delivery in prison are not educated on when to resume sex hence they end up getting pregnant without their intention to become pregnant. Many of them complain of this. As they said it's difficult to control their bodies.
- ▶ Post Natal Clinic at 6 weeks is minimum. Post-natal clinic is normal very important for mothers who have just delivered especial from first weeks to 24 weeks because most of the maternal death are recorded within this period. Therefore reviews are done to monitor how a mother is coping and the health of the baby. Hence absence of such facilities

exposed the mothers at the prison to danger of complication as it seen in quality of post-natal care in chapter two of this research.

The Safe Motherhood service are not accessible to the pregnant female inmates in Juba Main Prison

- ▶ They are not accessible because as we defined access as the right to utilise fully a given facilities obtains hence given the absence of many items the nearby facility become inaccessible despite it being few meter away from the given location. Concerning the possibility of affordability the researcher has also taken into consideration whether the poor women are able to afford to pay for some of these items and pay for the user fees. Female inmate who have complication during labour are not refer to the main hospital in time. Yes or no some time referred in time some time there are delays depending on the individual women involved.
- ▶ The save motherhood accessibility shall be problematic in the following.
- ▶ Accessing Antennal Clinic (ANC).
- ▶ Immunization and vaccination of mother and the baby.
- ▶ Lack of adequate money to procure other material as pregnancy is very expensive venture like Mama Kit.
- ▶ Power to avoid the 3Delays i.e. Delay from the prison to take decision on whether
- ▶ to take to the clinic or not, Delay looking for means of transport to transport her to
- ▶ The clinic, Delay at the medical facility.
- ▶ Lack of Pantographic.

The flowing are the facilities providing birth delivery to the female inmates at Juba main prison

Facility providing delivery	Number of institutions
Juba main hospital	1
PHC	4
NGO/ Private	16
total	21

Quality of comprehensive obstetric newborn care (CEMoNC) offered to the inmate at juba main prison.

The prison service to provide quality Safe Motherhood facility to pregnant women to deliver in a government institution despite female citizen failure to deliver in hospital facilities all over the country. This affirms on referral as seen in the relation to the following 9 signal function of maternal health at the facilities

1-Administration of parenteral antibiotic to the mothers.

It is acknowledged that the finding that all women giving birth from both the PHC and Juba Main Hospital are given parental antibiotics to the tune of 94% recorded during this data collection which was a positive indicator of quality and access to Safe Motherhood as seen from the data obtained from the data collection from the Juba Main Hospital.

Signal function	Percentages
Parenteral antibiotics	44 % out of 100
Parenteral oxytocic	39% out of 100
Parenteral anti-convulsants	31.5% out of 100
Manual removal of placenta	35.5% out 100
Removal of retained product	15% out of 100
Assisted vaginal delivery	7% out of 100
Newborn resuscitation	27 % out of 100
Blood transfusion	34 % out of 100
Surgery / Caesarean section	34% out of 100
	Total 240 out of 900. Hence its very low compared to WHO minimum requirement of 550-600 out of 900

(Source juba main hospital 2014)

2-Administration of uterotonic drugs (for example parenteral oxytocin).

Active birth delivery management by uterotonic drugs that are augmented for choice of control of the 3rd stage of labour in a given circumstance as a component of safe motherhood.

The table below shows uterotonic drugs administered to women and facilities at Juba Main Hospital.

facility	Drugs administered	Percentage
Juba main Hospital	Ergometrine	22%
Private	Ergometrine	5%
NGOs/Religious	Ergometrine	17%
Total		44% out of 100

(Sources ministry of health GOSS)

3-Administration of parenteral anticonvulsant for preeclampsia and eclampsia e.g. magnesium sulphate.

Preeclampsia and eclampsia are the most frequent cause of morbidities of pregnant women in South Sudan hence due to the result of poor management of delivery process more over it can be prevented as well as be treated by use of parenteral anticonvulsant like magnesium sulphate, Diazepam

Table showing administered of parenteral anticonvulsants by type of medication and facilities.

Facilities	percentage	Drugs 1	Drugs 2	Both
Juba main Hospital	6%	Magnesium sulphate	Diazepam	both
private	33%	Magnesium sulphate		One only
NGO/REG LIGIOUS	11%	Magnesium sulphate		One only
Total	50% out of 100 which is fairly good			

4-Removale of placenta manually. 5-Removal of retain product e.g. manual vacuum extraction, dilatation and curettage.

Removal of all retained substance or product from a mother is the most important aspect as a quality of safe motherhood. Most of this retained product if not removed cause a complication that result to maternal death. This done through D&C and curettage or E&C.

Facilities conducting removal of product by method and percentages.

Facilities	percentage	method		
Juba main Hospital	15%	MVA and Curettage	D&C OR E&C	
Private	5%	✓	✓	
NGO/Religious	7%	✓	✓	
TOTAL	27%	✓	✓	

NB only facilities that are of Hospital level are considered like juba complex Hospital juba main hospital and UN agents run clinical service where this inmate gets service. And Usuratuna Catholic hospital.

6-performance of assisted vaginal delivery e.g. vacuum extraction.

During data collection Assisted Vaginal Delivery (AVD) was not done in Juba Main Hospital. When asked why they could not perform the authorities were citing the following lack of training, lack of equipment supply and drugs. Except from private and NGO/Religious health institution making it the lowest performed signal function of Safe Motherhood. Most of the facilities used vacuum extractor exclusively at the private hospital like Juba Complex while NGO and religious health institution prefer vacuum extractor and obstetric forceps

7-Performance of neonatal resuscitation e.g. with bag and mask (1-7) basic service which was there at the Prison PHC but the staff cannot use

It due to lack of knowledge of how to use it. however resuscitation such as muscs extractor, infant face masks, ambu (ventilator) bag, suction catheter laryngoscope, endotracheal tube, disposable uncuffed tracheal tube, suction aspirator, and muscus trap for suction were absent and

the ambu bag which was present was not even used due to lack of training on how to use it. It should be acknowledged that resuscitation of a child with bag and mask is the basic signal of Safe Motherhood and EMoNC. Therefore all facilities are advised to have them as a measures for promoting Safe Motherhood.

8-performance of surgery e.g. caesarean section.

Here I concentrated on the three most recent females who underwent caesarean delivery within the last six months after successful discharged from the Hospital two from Juba Main Hospital government one from Juba Complex private. Through going into their history request, case history, medical history hence the implication for the outcome of the operation. Though the operation were comprehensive after time for recovering i.e. bed rest was limited for the inmate as they were forced to return to the prison cell and get some of the medication from prison PHC which is poorly equipped medically this becomes challenge. It often forced inmates to buy medical supplies from private clinics.

9-performance of blood transfusion

But, this is on condition that one need to have a relative who can donate blood in exchange for the blood that want not be given to the mother. This person can be husband, relative to the spouse, or brother to the inmates or sister. Therefore anybody who does not have the above personnel need to hire someone to help or they will face the trouble of transfusion of blood.

However the experience is different in the Private Hospital here the patient has to pay for the blood to the tune of 70 South Sudanese Pound (SSP) per litter but NGO do give free blood transfusion but the challenge is that they do not have a refrigerator big enough to store enough blood hence they are always hit by blood shortage as they depends for Nairobi Kenya and Kampala Uganda for their supply.

As well as patient who are able to pay for their medical bill of those who on medical insurance has to travel to Kampala or Nairobi for quality medical treatment. But as mentioned before in the chapter two of this book poor inmates who ca not afford such facilities of service are exposed to suffer as they cannot pay due poverty.

Why government is failing to comply.

South Sudan's failure to comply with Safe Motherhood package in the prison is due to the complexities of all plural legal mechanisms that are in place posing a greater challenge to the implementation of maternal health in the prison system as well as allocation of material resources and judicial procedure e.g. the customary courts and statutory approach hence pushing for financial assistance by the prison services. There is a clear indication that the Islamic laws are still an active influence risk to compliance. One day the president of South Sudan responded when asked by human right activist on compliance on women's prisoner health in south Sudan. He responded by saying:-

“[We] are only at the beginning of the long, winding and challenging road Of development.” –President Salva Kiir, Washington, DC, December 2011”

The continuing conflict in south Sudan also undermines the effort to comply with the international policy for safe motherhood initiation in prison as most set initiatives are destroyed by the conflict hence creating the failure of South Sudan to comply. Despite the achieved peace in 2005 after the signing of the comprehensive peace agreement CPA that brought South Sudan's independence in 2011 most parts of south Sudan continue to experience insecurity from factions of disgruntled war lords.

South Sudan still lacks laws and policy that can be used to comply with international obligation most of the policies are still under process in terms of Bills hence this curtails its compliance with international laws. South Sudan still lacks the technical personnel required to comply with the international laws e.g. These both need health background and legal backgrounds.

South Sudan does not adopt a multi sector approach like Rwanda to address its post conflict developmental problem e.g. in Rwanda after conflict of 1994 all the ministries worked together for example the Ministry of Health worked together with Ministry of Education in building capacity, Ministry of Agriculture worked together with Ministry of Health by solving nutrition, combined foreign affairs in mobilizing resources in bring donors Justice Ministry in assisting in making laws for health hence it was easier to comply with international treaties in given shortest period of time in Rwanda. However the prison commissioner South Sudan Prison service said that we are aware of our constitutional obligation in this country, and said this in quotes,

“South Sudan is founded on justice, equality, and respect for human dignity. And advancement of human rights and fundamental freedoms.”

–Transitional Constitution of the Republic of South Sudan, 2011.

Therefore South Sudan must comply with her obligation and honors its citation in her constitution. Because justice, equality and respect for human dignity are fundamental basic of international human rights.

It must be acknowledged that international laws are inheritable hence fourth there is a belief that, there was automatic inheritance of all basic human rights obligations from Sudan by South Sudan after independent in 2011 . Therefore ranging from the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of Persons with Disabilities (CRPD), 62 and the African Charter on Human and Peoples and Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

Juba Prison PHC Clinic

It's located within Juba Main Prison. With the following departments Midwives Department, Nursing Laboratory, Administration. It is headed by a Medical Assistant with a Visiting Doctor. The building has 8 rooms with a small Out of Patients department (OPD).It contained two admission wards both female and male, each with 8 beds respectively .Its PHC level i.e. Primary Health care.

They carry out ANC, Delivery, but do not provide Emergency Obstetric services to the female inmates. It is however facing some few challenges ranging from lack of flowing water, power, no delivery bed, poor working conditions, and no adequate qualified technical medical team and also faces serious under funding problem from the central government in order to meet all the maternal cost at the PHC. These deficiencies this are subject to delays even now.

, Lack of technical knowledge of the prison TBA to assess some of the danger signs, 2nd delay is the prison PHC as they lack communication equipment have no car, cell phone for communication as the inmates do not have money to hire a vehicle. The 3rd delay is from Juba

Main Hospital with poor drugs supply system some time there are no drugs no doctor on duty or senior Midwives.



The above is the map of south Sudan showing prisons location in south Sudan

Juba main Hospital maternity clinic.

Juba Main Hospital it's a national hospital that is for referral of cases nationwide. It handle more than 50 mothers per day. Given the inadequacy this facility to handle the over whelming and growing number of the population it suffer from accommodation problem. Many women though being in prison they are sheltered from the insecurity that the country is undergoing but still lack social insecurity especially in respect of child birth and pregnancy which even follow them and kill them in prison despite the safety that are given them. We still need to consider of the following,

Infections (from puerperal fever and retained placenta), hemorrhaging, or obstructed birth at the prison said one of the inmates

“The hospital is mainly supplies by UN agencies like UNFPA ,WHO MSF with all maternal related kits as government always complain of lack of resources to establish a functioning drugs system in the hospital.it has a blood bank with small family size refrigerator that cannot support the overcrowding number of women who are in drat need of blood transfusion”.

Below is the waiting maternity OPD of juba main hospital



Category of offence both on remand and convicted.

crime	Number	percentage
murder	6	4.8%
stealing	22	17.6%
adultery	45	36%
Mental health	12	9.6%
Kenotic	8	6.4%
assault	32	25.6%
total	125	100%

Lack of midwives.

It's estimated that well-trained midwives or skill attendant can prevent the death of mothers in a given country by 90% according to UNFPA maternal mortality 2014 on South Sudan. As their role is paramount right from conception during ANC and at the time of birth delivery. One senior medical official said Juba Main Hospital is not having enough drugs well trained staff despite it being a national referral center. Only 3 registered midwives manage the overcrowded maternity ward with all maternity consultation and procedure.

“We are only two on duty and a lot of the women number are increasing and remember we only have 8 bed only the rest are broken down for both labour and post-natal mothers she said.”

According to UNFPA 2014 report on South Sudan maternal human resources assessment south Sudan only has 8 registered midwives and 150 community midwives in the whole country hence many analysts stated that the condition at the prison PHC are no different from the main hospital the difference is only the name that, this is a PHC and the other is Hospital.

One professional lamented that TBA are not helping in preventing maternal death in this hospital instead they are aiding e.g. if the mother has post-partum hemorrhage they cannot help hence birth delivery here is a lottery especial when labour begins at night.

.Moreover midwives are considered backbone of reducing maternal mortality. They do not use partograph as recommended by WHO to improve Safe Motherhood

Treatment delays

“Many prison inmates are brought here when they are in critical condition or after failure to handle them at the prison as a last resort. As a result I always advise my colleague from the prison PHC to send us these mother early enough so that we are able to help them said Abdala a Dr in charge of maternity”.

Ministry of health response/government.

The South Sudan national health policy 2012 has banned TBA due to inadequate medical personnel the implementation remains only on paper. Hence giving us no option to replace the TBA. The community used to rely on this TBA .The TBA draws more support from the community as well the government. It should be known that during the civil war most of the births were conducted by the TBA in most part of south Sudan. Therefore through donor support the ministry should try to train many midwives as much as possible. But the question remains. When will this gap be filled by the Ministry?

The government is mobilizing more resources ranging from financial to other forms of material supports to offer a comprehensive as well quality safe motherhood to all of the citizen in South

Sudan especial the prison service through ensuring judiciously and accountable use of health activities to matinee value for money in health.

Development of a well-equipped maternal data base for information on the health system for Safe Motherhood related information is priority because it updates the national Ministry of Health as it improve on the area of Safe Motherhood.

The government through the directorate of Research in the national ministry of health has improved its focus by doing more research in the area of Safe Motherhood in bid to improve health and so as to identify most challenging issues facing maternal health in South Sudan so as to reduce the high maternal mortality. Research will set the objectives evaluation and strategies planning of policy.

Implementing and initiating reproductive health regulatory monitoring framework is a priority. This will ensure that the best work is in place both professional and ethical practice in the Safe Motherhood area in South Sudan through attracting and adopt the best health care practice from the countries that have performed best in maternal health particularly in safe motherhood. Because quality Safe Motherhood delivery in south Sudan is our main objective.

Achieving human resource building through optimism involves capacity development of personnel in terms both of numbers adequate to close the gap of inadequate man power for reproductive health service so that it runs efficiently and effective in all levels of the health care system in south Sudan.

To established a good number of adequate equipped PHC to capably offer basic and comprehensive Obstritic care to mothers in various part of the country.

To assure willingness and free access and quality of safe motherhood service to all mother to promoting health in South Sudan in order to reduce maternal mortality through the country.

To put in place possible measure to eradicate all forms gender based discrimination in south Sudan as advocated by CEDAW and create equality in health care that will promote dignity of all citizens of both sexes.

To established capacity building initiative within the hospital for training under qualified staff on job training for the effective diagnosis of problems and management of treatment with same

staffs deployed outside the hospital especial to the PHC. This will bridge the gynecological gaps in the PHC. Comprehensively making reproductive health accessible in prison for female inmate irrespective of sex, gender, tribe in South Sudan.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS.

Throughout my research, it is clearly reflected that despite South Sudan having inheritance and have started becoming a signatory to many international human Rights treaties ranging from ICCPR, CEDAW the government of South Sudan GOSS IS failing completely to provide evident access for women to Safe Motherhood in the prison despite the United Nation Mission in south Sudan UNMISS working side by side in building the capacity of the government of South Sudan in all Ministry within South Sudan.

South Sudan's rights from its transitional constitution to national policy, national health policy sounds very comprehensive in nature as if maternal issues are center of agent in ministry of health. However, given South Sudan's high maternal mortality of 2045/100,000 live birth is another indicator the government is smart on paper but less satisfactory on delivery. Hence enough have not been done. The facts are embedded in the Safe Motherhood poor condition at the prison PHC Juba.

The service that all offered by Juba Prison and Juba Main Hospital is characterized by TBA workload who are too poorly qualified to even reduce maternal mortality nor promote Safe Motherhood as WHO declared them TBA unqualified hence the lack of maternal standards compared to the much needed skilled birth attendance. Since 2005 the South Sudan interim period and 2011 post-independence no big effort has been put into construct or even renovate the health Center to promote the 1987 Nairobi Safe Motherhood initiative for the people of South Sudan. Despite all efforts put by the global body through the implementation of its millennium Development Goal south Sudan still poses a risk because of its unfinished agenda number 4 and 5 in the whole world despite a 15 year implementation program.

All the medical personnel both the Juba Main Hospital and Juba Main Prison lack a drugs supply chain and equipment like a pantograph as auto-sound etc. other maternal safe mother hood package to guarantee birth delivery and safe pregnancy. Hence the outcome of this is that women

and children continuing dying at the hand of a medical personnel who are supposed to save lives in these in this medical facilities. Therefore lam calling for the following;

Participation

Action to equip our female inmate (women) to acknowledge and voice all their claim of Safe Motherhood health and accessibility of all including educational material for maternal health provision.

Inclusion

Step up to minimize discrimination and enhance social equality social, which are pillar for promoting equality rather than only put women in a grouping of human being but risk/danger of maternal death in South Sudan

Fulfilling obligation

Accomplishment of the state and its relevant department/sector with their obligation of reducing maternal death in South Sudan through fulfilment and calling for accountability by the women and NGOs working to improve the plights of women in South Sudan.

Recommendations

South Sudan should stop putting a blanket ratification of all of the treaty, but not merely depending on her predecessor Sudan for the legality of the international law hence south Sudan is independent country and need to act on its own initiative. Therefore it need to sign and ratify all treaties so as to guarantee the right of the citizens to sue the State and to be sued. South Sudan inheritance of these treaty from Sudan is historical but it is mandatory for South Sudan to domesticate this law in order to create a conducive atmosphere that will encourage its governmental bodies to comply with is Human Rights obligations internationally and domestically for the safety of all of its citizens.

International bodies like UNMISS the UN body operating in South Sudan especially the civil affairs office of the deputy secretary general of the UN South Sudan chapter should persuade the South Sudan parliament, South Sudan Ministry of Justice within the East African block so as to put some of this law in place but not just as a member because Sudan was member of the treaties. South Sudan alone must create a law enforcement task force to see that mothers deliver in good place within a conducive environment regardless of being in prison or not hence acting as a sign of the government abiding by the laws.as well as Safe Motherhood.

Most of the South Sudan national health policy priorities are sufficiently maternal friendly to achieve this when a clearly allocated and budget is assigned to it by the responsible line Ministry of South Sudan. Because this helps the transformation of this health service with life threatening aspects. Health in action is own watched. Therefore, there is need for the legislation of all this policy to ensure that international instrumented are incorporated into this health policy as well as its justiciability in all pluralistic courts of South Sudan being it customary court of statutory court.

South Sudan health pool fund HPF should be geared towards improvement of Safe Motherhood as the way of achieving the missed millennium goal 5 so as to act as gap bridging measure with the sustainable development goal SDG 2030 agenda number 3,because South Sudan does not meet the MDG 5 in the last 15 years. Therefore it's time for South Sudan to adjust its strategic planning so as to cope up with the rest of the world in addressing maternal mortality.

There is need for South Sudan to full adopt the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) in her health policy .CARMMA is basically focused on basic maternal package area to improve maternal health in Africa. I.e. a heartening result and objective made in some countries in support of reducing maternal mortality as well adopting the best practice of these countries by other countries who also have high maternal mortality they need to provide an example as South Sudan attempts to curb to maternal mortality.

It should also aim at doing this through its campaign to reduce the maternal mortality of countries with high maternal mortality like South Sudan.

It's also based its factor on Africanism hence gearing on women sexual rights and subsequently their choice to sex, the aim to achieve gender equality, economic empowerment as well as informed and well decided health decision, armed conflict health situation analysis, stopping of early marriage and other related abuse, disease and unsafe sex education to all the citizen of south Sudan. Hence with comprehensive implementation of sexual Reproductive Health Service SRHS to all so as to allow women to have control over their bodies and change of Africa harmful culture towards women.

Therefore south Sudan should adopt the overall of objective of safe motherhood that state that no mother should be harm during pregnancy or after birth as well child. In all maternal health policy of south Sudan in order to address all those issues of lack of safe motherhood package in government health institutions.

It was from the finding of this research that malaria in pregnancy among the inmates had be identified as most frequent cause of pregnancy related complications. Therefore as malaria remains a most challenge cause in south Sudan the government need to interpret this finding along the line of the cause of remission of malaria, inmates personal protection from malaria through making available treated insecticide mosquito net to the inmates. And even embarking on national wide prison insecticide spreading program.

Most health assistance of the inmate's condition assessment are not done. Annual so as to discuss the finding across the two line Ministry of Health and Interior so as to come up with a join recommendation to handle the issues facing the female inmates and as well as formation of a prison health task force to oversee the health condition of female pregnant inmates and give relevant solution to the both Ministries for implementation of Safe Motherhood in the prison.

There is need to have all TBA capacity built up as they have huge experience in maternal health adult education .they ought to be given choice to them improve the mater within the short run as the ministry of health and education trains more midwives because research has shown that south Sudan in the short run cannot do without the TBA given the current health personnel shortage facing the country. And make policy that support because the current policy does not recognize the TBA yet their presence is needed by the Ministry of Health hence there is need to put in

place policy that protect them as they execute their duty in South Sudan to they need to avoid being be exploited by the community they are serving.

The prison act should allow for recruitment of a professional gynecologist and midwives into the prison institutions so as to have professional body among the prison wards serving within the prison system as to implement maternal health. Or at least open up course for the young officer to go for such educational training. Under the prison capacity building programs we need to bridge this lacked of personnel gap in the prison.

To reduce or avoid the 3Delay the PHC authority should partner with NGO or UN agencies to solve this problem by getting an Ambulance to help the inmate as they cannot hire car to transport them to the nearest health facility. This can be motor ambulance or motor cycle ambulance to help the inmate. Female pregnant inmate have to be give adequate maternal education so as to avoid decision making of how and where to give birth during this ANC secession.



A motorcycle ambulance used in some part of south Sudan Western Equator Ezo County

(Sources: Combining Tradition and Technology for Safe Motherhood: Success with TBAs in Bridging the Human Resource Gap in very Resource Limited Emergency Setting in South Sudan)

The government should focus on the reduction of maternal mortality targeting the PHC like Juba Prison PHC where hidden birth takes place in the country for the most vulnerable citizens in South Sudan through giving support to the development as well implementation of all health policies at all prison health facilities so as to guarantee and all human rights promote human rights at the Prison, create accessibility of health equipment in such facilities and maternal availability for both newborn and under 5age at prison. As well setting of obstetric services at the prison PHC need to avoid referral for just what can be done at PHC.

Finally, the government of south Sudan health statement as quoted below when put into action solve health issues

Policy Statements on: Health System Strengthening 2012

Reducing Inequalities in Access to Health Care

Primary Health Care and the Development and Implementation of the Basic Package of Essential Health Care

Development and Implementation of Essential Hospital Services Package

Quality Assurance

Development of Support Services

Health Facility Infrastructure Development

Institutional Development

Health Policy Development, Planning, and Evaluation

Human Resource Development

Health Financing

Sector Wide Laws and Regulations

Coordination, Communication and Networking

Pharmaceuticals and Medical Supplies

Traditional/Herbal Medicine

Information Technology and Communications

Procurement and Logistics

Health System Research

Put the above governmental objective into action

BIBLIOGRAPHY

Akukwe, C. ed. (2008) *Health Services in Africa, Overcoming Challenges, Improving Outcomes*. Adonis& Abbey Publishers, London

Banda, F. (2005) *Women, Law and Human Rights. An African Perspective*. Oxford-Portland Oregon, Hait publish

Bentzon A.W et al (1998). *Pursuing Grounded Theory in Law. South North Experience in Developing Women's Law*. Oslo ,Tano Ascheoug, Harare, Mond Books.

Chiremba, S and Masters W. (1990) *the Experience of Resettled Farmers in Zimbabwe*. African Studies Online Journal. Available Online on <http://web.africa.ufl.edu>

Clapham, A. and Robinson M. *Realising the Right to Health Swiss Human Rights Book*, Vol. 3 I. Ransom Yinger N.Rl (2002) *Making Motherhood Safer Overcoming Obstacles on the Pathway to Care*, Population Reference Bureau

Elizabeth, Wicks. (2007) *Human rights and healthcare*. WHOxford and patland or, Hart publish
Faida, T. and Heaton, M.M. eds (2008) *Endangered Bodies. Women Children and Health in Africa*. Africa World Press, Inc. Trenton NJ and Asmara.

Shiffman. J (2000) *Can Poor Countries Surmount High Maternal Mortality?* Studies in Family Planning 31, No. 4

Katzive. And Diourte FD. . (2003) *claiming our rights: Surviving Pregnancy and Child Birth in Mali*. Centre for Reproductive Rights New York

MOH, 2005, *the Southern Sudan National Drug Policy*. Ministry of Health, Government of Southern Sudan juba

South Sudan Ministry of Health MoH, 2005, *Prevention & Treatment Guidelines for Primary Health Care Units*. Ministry of Health, Government of South Sudan

SPLM SOH, (2004), *laying the grounds for the recovery of the health sector in a post conflict Southern Sudan*. Secretariat of Health, Sudan People's Liberation Movement

SPLM SOH, (2004), *Framework for Action in 2005 – 2006*. Secretariat of Health, Sudan People's Liberation Movement

SPLM SOH, (2001), *HIV/AIDS Policy and Control Strategies for the New Sudan*. Secretariat of Health, Sudan People's Liberation Movement

SPLM SOH,(1999,) *Guidelines for the Implementation of the Health Policy of the New Sudan*. Secretariat of Health, Sudan People's Liberation Movement

SPLM SOH,(1998), *Health Policy of the New Sudan*. Secretariat of Health, Sudan People's Liberation Movement.

SPLM SOH, (1994), *Health Policy for New Sudan*. Secretariat of Health, Sudan People's Liberation Movement Health 92

Zimbabwe Ministry of Health and Child Welfare (2011) *The Neonatal Roadmap of Zimbabwe*. Ministry of Health and Child Welfare Harare

Ministry of Health. (2011) A multi-donor pooled fund for health in Zimbabwe. Supporting the National health strategy to improve access to quality health care in Zimbabwe. Ministry of Health

Munjanja, P.M. (2007) *Maternal and Mortality Study*. Ministry of Health and Child Welfare
Physician for Human Rights (2009) *Health in Ruins A Man-Made Disaster in Zimbabwe*
Cambridge, MA. The Standard (17/12/2011) ***rural-women-turn-to-traditional-midwives.***

Tumwine, JK. (1991) Experience with training of traditional midwives on the prevention and Management of birth asphyxia in a rural district in Zimbabwe. US National Library of Medicine National Institutes of Health Also Available online on <http://www.ncbi.nlm.nih.gov/pubmed/>
UN. OHCHR (Committee on Economic, Social and Cultural Rights, General Comment No. 14,) *The Right to the Highest Attainable Standard of Health* (hereinafter CESCR General Comment No.14)

WHO (2011) *Ten Facts on Midwifery*. WHO Also Found online on <http://www.who.int/features/factfiles/midwifery>

Bryce J, Terreri N, Victora CG, Mason E, Daelmans B, Bhutta ZA, et al. Countdown to 2015: tracking intervention coverage for child survival. *Lancet* 2006;368(9541): 1067–76.

Rosen field A, Maine D, Freedman L. Meeting MDG-5: an impossible dream? *Lancet* 2006;368(9542):1133–5.

United Nations. The Millennium Development Goals Report 2013. <http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf>. Published 2013. Accessed December 20, 2013.

Kinney MV,l. Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? *PLoS Med* 2010;7(6):e1000294.

Pearson L, Shoo R. Availability and use of emergency obstetric services: Kenya, Rwanda, Southern Sudan, and Uganda. *Int J Gynecol Obstet* 2005;88(2):208–15.

Campbell OM, Graham WJ; Lancet Maternal Survival Series steering group. Strategies for reducing maternal mortality: getting on with what works. *Lancet* 2006; 368(9543):1284–99.

Freedman LP, Graham WJ, Brazier E, Smith JM, Ensor T, Fauveau V, et al. Practical lessons. From global safe motherhood initiatives: time for a new focus on implementation. *Lancet* 2007;370 (9595):1383–91.

World Health Organization, United Nations Population Fund, United Nations Children's Fund, Averting Maternal Death and Disability Program. Monitoring emergency Obstetric care: a handbook. http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf. Published 2009. Accessed December 20, 2013.

Kongnyuy EJ, Mlawa G, van den Broek N. Criteria-based audit to improve a district referral system in Malawi: a pilot study. *BMC Health Serv Res* 2008;8:190.

Somigliana E. A Comprehensive and integrated project to improve reproductive health at Oyam district, northern Uganda: insights from maternal death review at the district hospital. *Arch Gynecol Obstet* 2011;283(3):645–9.

Minister of Health, Government of South Sudan. Health Sector Development Plan, 2011-2015. Transforming the Health System for Improved Services and Better Coverage. <http://www.gunneweg-imprint-consultants.nl/wp-content/uploads/2011/10/HSSDPL2010-2015-SOUTH-SUDAN.pdf>. Published March 1, 2011. Accessed December 20, 2013.

Somigliana E, Sabino A, Nkurunziza R, Okello E, Quaglio G, Lochoro P, et al. Ambulance service within a comprehensive intervention for reproductive health in remote Settings: a cost-effective intervention. *Trop Med Int Health* 2011;16(9): 1151–8.

Southern Sudan Centre for Census, Statistics, and Evaluation. Southern Sudan Counts. Tables from the 5th Sudan Population and Housing Census, 2008. <http://ssnbs.org/storage/SPHC%202008%20tables.pdf>. Published November 19, 2010. Accessed December 20, 2013.

Taylor-Smith K, Zachariah R, Manzi M, Van den Boogaard W, Nyandwi G, Reid T, et al. An ambulance referral network improves access to emergency obstetric and Neonatal care in a district of rural Burundi with high maternal mortality. *Trop Med Int Health* 2013;18(8):993–1001.