THE ACCESSIBLITY TO AND QUALITY OF SAFE MOTHERHOOD FOR FEMALE INMATES AT JUBA MAIN PRISON, SOUTH SUDAN

By

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Abstract

Conscious of the sad reality that South Sudan has the highest maternal mortality rate in the world (2,045 for every 100,000 live births), the writer, a safe motherhood specialist of the Reproductive Health Association of South Sudan (RHASS), employs a case study approach of female inmates in Juba Main Prison to examine the quality of their accessibility to decent Safe Motherhood treatment at its Primary Health Care Clinic, Juba Main Hospital as well as other private and NGO/religious hospital facilities in Juba. This research (apparently the first of its kind) implements a combination of methodologies, including the grounded and human rights approaches, within the ambit of the overarching Women's Law approach, to highlight the gap between the Government's promises to realize the inmates' maternal health rights within the Safe Motherhood programme and its actual failure to do so. This has resulted in increasing mortality rates for mothers in and out of prison. The research relies on 'the lived realities' of the prison inmates which is built upon data retrieved using gender-sensitive collection methods including research into the relevant literature and law on the subject, interviews and discussions with carefully selected women respondents and officials and staff of government organisations (GOs) and non-government organisations (NGOs). It is established that, while giving birth, many mothers (most of them poor, illiterate and ignorant of their rights) die or suffer life-threatening injuries in the most appalling and avoidable of circumstances in the prison or at or on the way to Juba Main Hospital. This dire situation is mostly due to the Government's apparent breach of its duty to realize the women inmates' right to maternal health care by, *inter alia,* failing to maintain and properly equip the prison's clinic or maternity facilities at Juba Main Hospital and failing to train compassionate but frustrated and helpless medical staff members, especially traditional birth assistants (TBAs), in basic Safe Motherhood skills. Finally, the writer makes some worthwhile recommendations including: educating women about their rights to Safe Motherhood, undertaking immediate legal reform to make the right to Safe Motherhood health care justiciable in terms of South Sudan's obligations enshrined in various local, regional and international human rights instruments; officially recognizing, supporting and enhancing the skills of TBAs whose critical services have already saved the lives of countless desperate mothers and the immediate purchase and deployment of ambulance motor cycles. These measures can be partly financed by NGO funds which are currently available to the prison.

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Declaration

I, GODSON REUBEN LADU JOSEPH, do hereby declare that this thesis is an original piece of work presented in partial fulfilment 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) 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.

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My special gratitude goes:

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ACHPR	African Charter on Human and Peoples' Rights
ANC	Antenatal care
ART	Anti-retroviral therapy
AVD	Assisted vaginal delivery
BCC	Behavioural change communication
CARMMA	Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEMoNC	Comprehensive Emergency Obstetric and New Born Care
CN	Certified Nurse
CPA	Comprehensive peace agreement
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CWHRPWG	Coalition for women human rights parliamentary watch group
ECHR	European Commission on Human Rights
EMoNC	Emergency obstetric newborn care
EU	European Union
FGD	Focus group discussion
FP	Family planning
GO	Government organisation
GOSS	Government of South Sudan
HIV	Human Immunodeficiency Virus
HPF	Health Pool Fund
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IMR	Infant mortality rate
JMP	Juba Main Prison
MDG	Millennium Development Goal
MMR	Maternal mortality rate
MOH	Ministry of Health
MNH	Maternal and Newborn Health

MSF	*Medicins Sans Frontiers* (Doctors Without Borders)
NGO	Non-governmental organization
OPD	Out-patients department
PMTCT	Prevention of mother to child transmission of HIV Aids
PHC	Primary Health Care
PHCC	Primary Health Care Clinic/Centre
PHCU	Primary Health Care Unit
RHASS	Reproductive Health Association of South Sudan
RN	Registered Nurse
ROA	Result-Oriented Approach
SDG	Sustainable Development Goal
SHRS	Sexual Health Reproductive Services
SSP	South Sudanese Pound
SSPA	South Sudan Prison Act, 2008
SSRC	South Sudan Red Cross
TBA	Traditional birth attendant
TCSS	Transitional Constitution of South Sudan
UNMISS	United Nation Mission in South Sudan
UN	United Nations
UNICEF	United Nations Children's Fund
U5MR	Under five mortality rate
WHO	World Health Organization

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CHAPTER ONE

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

Given the high maternal mortality rate in South Sudan, our main objective at the Reproductive Health Association of South Sudan's (RHASS) Clinic is to make it a centre of excellence in the provision of Safe Motherhood to all women in South Sudan. This means giving all women accessibility to high quality treatment resulting in the promotion of Safe Motherhood throughout the country. It is against this background and having enrolled for the Master's degree in Women's Law at the University of Zimbabwe that the writer decided to use this study to answer the following questions.

If the condition of Safe Motherhood and its accessibility and quality are currently very poor in South Sudan, what is the likely fate faced by those vulnerable women who are incarcerated in the country's prisons? Are they accessing quality Safe Motherhood given that such prisons are operating under the control of the government and its rules and policies? Where in South Sudan do expectant mothers in prison go to access vital facilities for the delivery of their babies? The aim of this research is to interrogate the quality and accessibility of Safe Motherhood or what is known as the Safe Motherhood package for female inmates in Juba Main Prison (JMP).

1.2 The concept of the Safe Motherhood package

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

1.2.1 Family planning

Family planning is the process of considering the taking of contraception by any married or unmarried person (who is committed to a lifelong relationship) in their decision concerning if and when to conceive or to have a child. It also involves the major decision of what kind of contraception to take and why. This is always influenced by number of issues such as career, financial problems and disabilities as well complications to one's health that may affect the outcome of a pregnancy. Family planning is often defined as the educational aspect of the Safe Motherhood package and deals with the social aspects of an individual's life or lived

reality and is designed to help them (be they minors or adults) to make their choice freely to either regulate their health or avoid unwanted and unintended pregnancy. Some women who come to the prison have already made up their minds and are already taking family planning drugs. If they are not yet already on contraceptives, however, they may choose to go on them while in prison. It is important for their health that 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 provided to them in fulfilment of their human rights.

1.2.2 Antenatal care (ANC)

Antenatal care is sometimes referred as prenatal care. It refers to preventive health care given to expectant mothers through the provision of regular medical check-ups by doctors or midwives in order to avert potential health threats throughout the pregnancy. The screening of both the mother and the child involves providing maternal physiological support, prenatal nutritional advice like the importance of taking prenatal vitamins by both mother and child. This is done during monthly visits (from 1 to 28 weeks of pregnancy), fortnight visits (from the 28th to the 36th week) and weekly visits from the 36th week to the time of delivery.

Women who arrive at the prison and are already pregnant need to be given antenatal care. It is mandatory for a good pregnancy and delivery. Most dangers in pregnancy are screened for and treated during this period. In addition, pregnancy monitoring is done through regular checks carried out during this stage.

It is important to ascertain when women who are in prison fall pregnant. One preliminary research finding is that some women arrive at the prison already pregnant. Others fall pregnant while their cases are pending, i.e., after they are arrested and charged, they are granted bail which allows them to go back to their family during which they fall pregnant. Others fall pregnant within the prison in unclear circumstances and when this occurs the authorities investigate.

1.2.3 Clean and safe birth delivery

Birth is the usual natural outcome of a pregnancy. For a clean birth to take place, the following are required: clean hands; clean perineum; clean delivery surface; clean cord

cutting; clean cord tying and clean cord care. All these can be achieved through the use of what is called a Mama Kit that contains the following: clean soap for washing hands and the perineum; a clean piece of plastic (40cm x 20cm) to provide a 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 available at the prison's Primary Health Care (PHC) facility. Therefore female inmates have to buy them. If they have the money to do so, all well and good, but, if not, they become exposed to the risks of delivery discussed later in chapter four on the study's findings. The above items are put in a box called a Mama Kit or Delivery Kit which is accompanied by a pictorial instruction sheet or manual that includes information about the birth process and how to effectively use the provided material to achieve a quality 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 personnel as indicated by the WHO's Report, 2012. Where possible, they should not be delivered by traditional birth attendants (TBAs) who may or may not have the full range of medical equipment and supplies such as Mama Kits.

1.2.4 Postnatal care and new born care

The WHO's (2012) definition of the terms 'postpartum period' and 'postnatal period' are often used interchangeably, or separately, while '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 considered a high risk period for both mother and child. Many complications can occur especially from the first day to week six after the delivery. Therefore the 42 days of care after birth must be attended to by both skilled attendants and family members in order to prevent risks of harm. Most of the findings concerning the PHC facilities at Juba Main Prison show that inmates who give birth in the prison are assigned three older fellow women to take care of them but this has been found to be inadequate to avert post-natal complications as they lack the basic knowledge needed to detect likely complications for both mother and baby. For instance, one of these care givers was asked:

> ‘Assuming the baby is crying?’

She responded:

> ‘Of course, it’s normal for a new born to cry; if the baby don’t cry, it mean there is problem.’

But a midwife who was asked the same question responded:

> ‘Babies do not cry much after birth, so a continual cry means the baby is experiencing a pain sustained during birth or infection.’

These findings therefore explain the need for skilled attendance at the postnatal stage.

Postnatal care is important because this period requires a series of important medical procedures that need to be conducted like immunization and other routine measures that are taken to minimise infection as the child is exposed to the harsh environment of the world for the first time.

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 the eighth week after birth and the resumption of sex. Therefore, such care is a very important aspect of the Safe Motherhood package.

1.2.5 Emergent obstetric newborn 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 haemorrhages and other major complications that can result in maternal disability or even death.

1.3 Discrimination at the prison

Discrimination against women is the subject of gender discussions in all aspects of pre-natal and post-natal development. I am concerned about discrimination at Juba Main 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 uneducated and 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 their non-educated fellow prisoners go to the poorly equipped government facilities such as Juba Main Hospital. This clearly shows that education is a tool which is ideal for promoting women's fundament rights at all levels.

1.4 South Sudan's delivery of Safe Motherhood

Worldwide 287,000 (2002) mothers die every year in child birth. South Sudan's maternal mortality rate (MMR) is 2,045 for every 100,000 live births, her infant mortality rate (IMR) is 64 live births for every 1,000 and her under five mortality rate (U5MR) is 99 deaths per 1,000. Her average citizen's life expectancy is 55 years. It is estimated by the WHO in 2014 that 2.6 million children were still-born and that contributes to a mortality rate of 3 million infants within the first months of delivery, contributing to 44% of deaths worldwide of children below 5 years of age.[1]

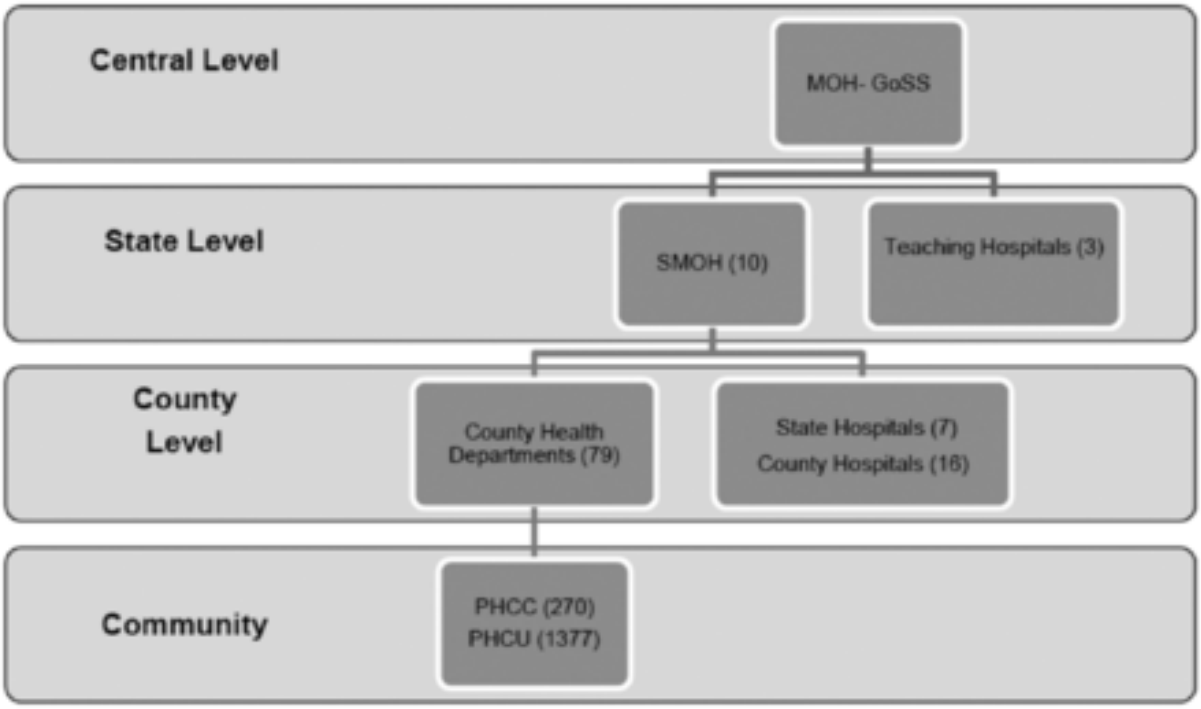
It is estimated that 80% of the maternal deaths worldwide are taking place in developing countries like South Sudan which is still undergoing development and addressing its post-conflict health agenda brought about by decades of civil conflict fought between the then Sudan and Southern Sudan. These war conditions led to the country's poor health infrastructure and since the launch of the Safe Motherhood Program in 1987, the on-going but retarded development of South Sudan's health and human resources have become an obstacle to its achieving Millennium Development Goals 4 and 5 by 2000 (UN WHO, 2013).

South Sudan's high MMR and IMR figures remain some of the worst by world standards despite the Peace Agreement signed in 2005 between the then rival South and North Sudan governments that eventually led to South Sudan's Independence in 2011. South Sudan has only 120 trained doctors according to the Ministry of Health (MOH) and only a very few nurses. They were trained during the war years. This huge deficit in its health care resources has prevented South Sudan from delivering on its Safe Motherhood programme since its welcomed and enthusiastic launch in 1987 and its objectives had still not been met by the year 2000.

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

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, 79 County Health Departments and 270 Primary Health Care Centres/Clinics (PHCCs) (Juba Main Prison is among these) and finally 1377 Primary Health Care Units (PHCUs) in South Sudan. The diagram in Figure 1 shows the institutions and structures in which the government has attempted to establish Safe Motherhood facilities in South Sudan.

Figure 1: Diagram showing the institutions and structures within the Ministry of Health in which the Government of South Sudan has attempted to establish Safe Motherhood



[2]

(Source: Ministry of Health and Government of South Sudan, 2011)

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

1.5 Accessibility to Safe Motherhood

Most NGOs (like UNFPA and WHO) have through their agents tried to provide the Safe Motherhood package to all citizens in South Sudan. However, their achievements have been undermined by the frequent conflict which still occurs in South Sudan and the lack of accessibility for women living in remote areas of South Sudan which lack the social infrastructure required to establish Safe Motherhood.

Obstacles to physical accessibility

When evaluating accessibility to Safe Motherhood, obstacles to physical accessibility must be considered and these include:

(1) The long distance between the health facility and the community it serves

(2) Technical obstacles

(3) The problem of morbidity in the challenge of avoiding the 3 Ds, or types of delays, which occur at critical times and these are:

- The delay in the time taken by the prison in deciding where the mother should deliver her baby;
- The delay in moving the expectant mother to the facility where it is decided she should give birth caused as a result of the prison personnel's difficulty in finding transport;
- The delay at the hospital when the expectant mother must wait to receive the necessary treatment from the doctors/midwives on duty.

Ability to pay prescription fees

The fee and user fees charged by the facility to the female inmate and other users are changeable.

Data (information)

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

The meaning of 'access'

The Oxford English Dictionary defines 'access' as the potential or opportunity to use a product or service or both. In my thesis I consider access to mean the right to Safe Motherhood by a pregnant inmate of Juba Main Prison.

'Access' includes the full utilization of a facility ranging from family planning (FP), including antenatal care (ANC), clean and safe delivery, and postnatal care and new born care and the provision of full comprehensive emergency obstetric care. In addition, subsequent treatment and the prevention of malaria in pregnancy are also covered (since it also contributes to maternal mortality in South Sudan[3]) as well as the administering of and prevention of mother to child transmission of HIV Aids (PMTCT).

In the past years 1 out of 10 women have died annually in Juba Main Prison as a result of complications resulting from pregnancy, still births or obstructions in labour as Safe Motherhood at the prison is in a poor state. Every year we, as Safe Motherhood advocates, celebrate International Safe Motherhood Day in South Sudan by joining with both international and national NGOs to call for a reduction in South Sudan's maternal mortality rate by lobbying for all PHCCs to be properly equipped. We draw the government's attention to putting in place all the resources that will help vulnerable women in villages and prisons to obtain access to Safe Motherhood. Despite the government of South Sudan's policy to prioritise Safe Motherhood (Reproductive Health 2008-2011; National Health Policy), it has failed to achieve its goals because maternal health is still not considered to be a human rights issue.

For example, on 3 May 2016 the Sudan Tribune's new website carried a report headlined:

'"Sanitary condition in Torit State prison inadequate," say women's groups.'

In this report the coalition for women human rights parliamentary watch group (CWHRPWG) said that they felt abandoned. They claimed that the 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 living with sewage

[3] South Sudan prison maternal mortality report 2014.

and rubbish in their cells. Dina Disan, the representative of the women's coalition, was quoted as saying that she was alarmed by the media's description of the very poor conditions of the women in Torit prison.[4] Figure 2 is a photograph of women prisoners in Juba Main Prison receiving a visit.

Figure 2: Photograph of women inmates of Juba Main Prison

Part of the newspaper article reads:

> 'The coalition expressed dismay claiming that the government had turned a blind eye to the way in which female prisoners were held in South Sudan prisons. A state sponsored prison seems to tolerate that fact that female prisoners are housed in cells 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.'

The condition of Juba Main Prison may be similar to that of all South Sudan's prisons. Although it is the main national prison, little significant effort has been made by the government, the local authority or international actors of United Nation Mission in South Sudan (UNMISS) to keep it clean. Achieving Safe Motherhood for women inmates has

[4] (http:/www.sudantribune.com/local cache_vegnettes/L.2&5xH258/the sewage system_in_the_torit state_prison_7c9dojpg).

remained a big challenge for all prisons in South Sudan. However, the woman government member in charge of Juba Main Prison (JMP), Major Haram, is confident that the government will investigate the matter as it (the government) had successfully campaigned for the rights of women prisoners to be included, recognised, protected and promoted in the Transitional Constitution of South Sudan (TCSS) and the South Sudan Prison Act, 2008 (SSPA).

1.6 Statement of the research problem

Since the launch of the Safe Motherhood program in 1987 in the former Sudan, the target of implementing South Sudan's prison health system's objectives and goals has largely not been achieved. These goals and objectives included among others improving the wellbeing of women while giving birth and adopting Comprehensive Emergency Obstetric and New Born Care (CEMoNC). It was the government's policy to rehabilitate all health institutions by the year 2000. However, by that date no Safe Motherhood pillars had been established in South Sudan's PHC prison services. After Independence in South Sudan in 2011 the Juba Prison PHC was not improved and even by the time of this study, the provision of Safe Motherhood to all its female inmates has still not been achieved and remains a challenge. For example, the Family Planning Desk and commodity ANC office at Juba Main Prison has no examination bed or screening equipment. The Delivery Ward does not have the 9 functioning requirements for safe birth delivery and offers no Emergency Obstetric Care. This is all in spite of the fact that the PHC has been located there for some time. In summary, it has become impossible for pregnant inmates to access quality Safe Motherhood at Juba Main Prison. This places them in danger unless they are moved to Juba Main Hospital to access Safe Motherhood services. Figure 3 is a map of the locations of prisons in South Sudan.

Figure 3: A map of the location of prisons in South Sudan

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 The literature on Safe Motherhood

Safe Motherhood is the concept that says that no woman or foetus/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 on emergency obstetric care (South Sudan MOH, Reproductive Health Policy, 2010, 38).

The importance of ANC

Antenatal care is one of the principle pillars of Safe Motherhood, and includes the following key components - screening for pregnancy risk factors, disease prevention, detection, and treatment, case referral and health education (WHO, 1999; Bhasker *et al.*, 2001). 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 services and so the quality of service given at this stage may have a lasting impact on future readiness to seek medical assistance (Safe Motherhood newsletter, 1993).

Lack of antenatal care attendance has been consistently associated with negative outcomes of pregnancy (Ryan *et al.*, 1980). South Sudan researchers found that over 67% of all maternal deaths was associated with non-attendance of antenatal care (Agel, 1994; Wandabwa and Murokora, 1997) and similar findings have been made in Thika, Kenya (Ruminjo, 1990) and in Nigeria (Ekwempu, 1988). These researchers postulate perceived poor quality care as one of the reasons for non-attendance. It is therefore, important that centres offering antenatal care address that the question of quality care if they are to attract clients and reduce rates of morbidity and mortality.

The national strategy to improve reproductive health in South Sudan recognizes the need for increased access to quality, goal-oriented antenatal care as one of the key pillars to reducing maternal mortality and morbidity and promoting women's health (MOH, 2010). According to the WHO the following may used as guidelines to improve 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 antenatal care, there will be reduced maternal mortality rates and infant mortality ratios.
- Antenatal care services also need to link up with quality emergency obstetric services in the event women experience complications at any time during their 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, the following objectives are used as guidelines to help us to refocus on improving 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 and 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 (including, blanket/ towels, clean plastic cover, clean razor blade, clean setting).

(4) Develop a 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 physically, psychologically and socially.

Good Quality Safe Motherhood

The quality of Safe Motherhood is determined among other things by accessibility, affordability, appropriateness of services and quality of care (Marshal, 1984). In Papua New Guinea, Nyalander and Adenkule (1999) 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'. In South Sudan 92% of all women in both urban and rural areas do not enjoy the benefits of safe motherhood (SSBS 2006/2009). Even among those who have access to Safe Motherhood facilities and clinics, only 42% end up delivering in health facilities. Since perceived quality of care is a key reason for utilizing delivery services (Kusasira, 2004), it is logical to presume that poor quality services is a likely reason for the low utilization of 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) The 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, anaemia, heart disease, diabetes, malnutrition, and tuberculosis may affect the outcome of pregnancy, and they require immediate treatment, and they also usually require a more intensive level of monitoring and follow-up care over the course of pregnancy.

(2) The 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 anaemia, infections, vaginal bleeding, hypertensive disorders of pregnancy, abnormal foetal growth or abnormal foetal position after 36 weeks are or become life-threatening if left untreated.

(3) Health promotion and disease prevention. Counselling 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 the 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 counselling and testing for HIV.
- Protection against malaria with intermittent preventive treatment and insecticide-treated bed nets.

Good quality Safe Motherhood services addresse the technical competencies of the provider, provider-client interaction and the adequacy of essential logistic supply (Bergstrom, 2001).

A study carried out in South Sudan (UNFPA 2010) identified 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) 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).

The Ministry of Health in South Sudan prescribes the following to be part of the minimum package at antenatal clinics: information, education and communication on risk factors and warning signs, provision of hematinic, prophylaxis for malaria, STI screening (including HIV counselling and screening). The expected minimum amount of staff and equipment 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, Safe Motherhood should provide care to pregnant woman from the moment a 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 counselled on infant feeding. Some of the objectives at this stage are to:

(1) Assess and maintain the physical and mental wellbeing of the mother and her unborn 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 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 her 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 providers other than obstericians/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/gynaecologist-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 about decisions that will need to be made about when to seek care and where to go. When only one person is responsible for making such decisions, it is important to establish an alternative plan for decision-making if there is an emergency and the chief decision-maker is absent. A husband or mother-in-law may be the primary decision-maker and a decision should be made in advance about who should make important decisions in the future if they are absent. In prison the officer in charge take on 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 case of an emergency. In too many cases, women do not seek care because they do not have the necessary funds.

The decades of 1970 and 1980 witnessed and acknowledged that maternal mortality was a threat to the development of human life throughout the world. In many advanced countries,

maternal mortality figures and statistical data on maternal health were beginning to improve based on information recovered from worldwide data collection centres on maternal health. This was not the case, however, with underdeveloped countries and WHO carried out a maternal mortality data survey and census in the 1970s as a first step in its attempt to reach a breakthrough solution to global maternal mortality, a problem still largely hidden from a world unable to fix it.

It was not until 1985 did the WHO with financial assistant from UNFPA carry out the first ever maternal community studies programme for the cause and the impact of maternal mortality and find a way forward. Through the collection of hospital data, vital and preventable neglect was found. A major finding was that half a million maternal deaths were taking place every year. Developing countries or under-developed countries like South Sudan accounted for 99% of the world's mortality rate statistics.

In 1987, Dr. Hafdan Mahler, who was then the WHO Director General advocated that maternal health measures be given priority due to the appalling statistics produced by the survey. He gave his recommendation to the world body to consider such measures at the joint WHO, UNFPA and World Bank launch of the first international Safe Motherhood Conference in February 1987 in Nairobi, Kenya. It was at this conference that Safe Motherhood was identified a cornerstone of public health and, henceforth, Safe Motherhood was placed on the world agenda for discussion and action.

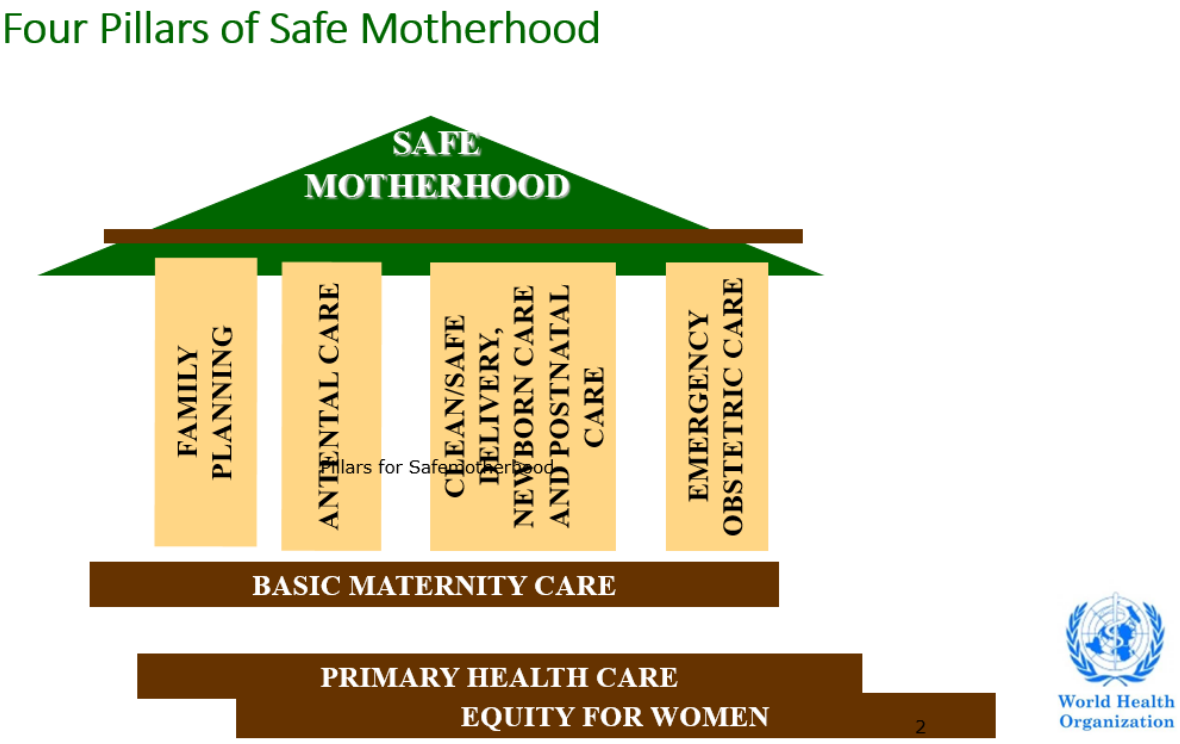
Safe Motherhood continues to be complex in nature as it is treated as a subset of other reproductive health programmes. Also, it only receives limited economic support. Increased support for Safe Motherhood is most likely only possible through mobilising political will at state, regional and international levels. And because of the continued rise in mortality rates advocates of Safe Motherhood at all these levels must continue to press for the promotion of Safe Motherhood,[5] especially for the funding of staff in the form obstetricians, gynaecologists and other human resource specialists as well as the acquisition of Safe Motherhood medical equipment.

[5] 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

It is estimated that in 1900 USA maternal mortality figures were 700 for every 100,000 live births but by 1990 this figure eventually declined to 10 maternal deaths for every 100,000 live births due to the promotion of Safe Motherhood in their health systems.

According to the WHO fact sheet on Safe Motherhood, maternal mortality can be reduced or even eradicated if the directions outlined below are followed. Figure 4 shows the four pillars of Safe Motherhood.

Figure 4: Diagram showing the 4 Pillars of Safe Motherhood



Quality antenatal care

The world health organization (WHO) has recommended a model care package to achieve quality Safe Motherhood which it believes is economical and affordable for an individual or government agency. This model includes 4 to 5 antenatal visits to avoid maternal complications from pregnancy onwards. They are intended simply to detect and prevent any early danger signs of pregnancy-related outcomes for both the baby and mother. They include conducting the following checks.

- Routine blood pressure checks.
- Examination of urine for bacteria and protein.
- Screening of the blood for anaemia and possible treatment for some abnormalities that may have an impact on the pregnancy ranging from Tuberculosis, Hive, Malaria, sex-related infections, Hookworm and monitoring the possibility of malnutrition signs and symptoms.
- Frequent height and weight measurements on every visit.

The philosophy of such antenatal care is simply to detect, prevent and prepare for birth through health education.

Quality family planning

- Improvement of communication between the mother and midwives to avoid unintended pregnancy.
- Training of service providers to enhance technical skills and improve attitudes. The WHO (2010) recommends skilled attendants rather than TBAs.
- 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 within the health system.
- Improvement of record keeping.
- Strengthening of the follow-up, supervision and referral systems.
- Increasing service points.

Quality delivery care

- Information on signs of labour, what to expect and what ought to be done by skilled attendants rather than TBAs.
- Monitoring and documenting labour to improve the referral system.
- Referral if it becomes necessary.
- The provision of clean supplies.
- The provision of the necessary drugs required for pain relief and delivery.

- Communication with family members, especially the spouse.
- HIV testing and counselling.
- Counselling on infant feeding options.

Quality postnatal and newborn care

- Information on danger signs, what to expect and what should be done by experienced midwives.
- Immunization for both mother and baby.
- Counselling on infant feeding options.
- Maternal wellbeing-nutrition, workload.
- Responsible fatherhood.
- Family planning options.
- Resumption of sex.
- Postnatal clinic at 6 weeks.

Safe Motherhood's potential to reduce mother and child morbidity rates in PHC in prisons worldwide

It is estimated that 1,000-1,500 mothers and newborn babies die annually due to complications that can be easily prevented through observing the Safe Motherhood aspects of its clean and safe delivery and post-natal care package. The WHO claims that the skilled attendance package of Safe Motherhood can address all the above risks.

The 1990-2015 Millennium Development Goal (5) focused on providing Safe Motherhood through increasing the training of more midwives and skilled birth attendants by 95% by 2015 which is also supported by Sustainable Development Goal Number 3 which promotes providing the best care during and after birth as well as initiating breast feeding immediately after birth. This all plays a big role in the process of stopping and preventing mother to child transmission of HIV Aids (PMTCT) throughout the ANC screening process.

It is estimated that worldwide only 3 out of 10 health workers are trained or have acquired skills in Safe Motherhood which means that almost all PHC facilities in health centre institutions in developing countries lack specialized Safe Motherhood staff. Therefore these

countries should now redistribute and deploy their resources and give their attention to improving their performance in the area of Safe Motherhood.

Time, the most important element of the Care-giving Continuum

As shown in Figure 5, time is the most important element connecting the various care giving stages on the continuum from pre-pregnancy, through to pregnancy, child birth, and the early days and years of life.

Figure 5: Diagram showing the continuum of care-giving around child birth

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

All the components of Safe Motherhood

Pregnant mothers need access to the full safe motherhood package ranging from family planning, ANC, clean and safe delivery and obstetric care. Apart from the lack of a complete drugs supply chain in PHC and hospital facilities, other components of the entire Safe

Motherhood package are missing and this leads to maternal deaths in cases where, e.g., there are delivery rooms but no delivery beds or equipment.[6]

The storage and management of Safe Motherhood information

In the absence of a comprehensive data base, it is very difficult if not impossible to know how many women are enrolled for family planning, the number of women attending ANC, mother and child morbidity rates or to establish the crucial flow of statistical data and information necessary between hospitals, PHC, PHCU and government to establish and develop Safe Motherhood policy.

Many African countries find it difficult to maintain quality Safe Motherhood due to the complexities involved in implementing it as they are primarily focused on the training of midwives and gynaecologists who lack specialized Safe Motherhood skills. This has created a health gap which has caused the continued increase in maternal deaths even where resources are being ear-marked for Safe Motherhood.

WHO focuses its advice on how to train Safe Motherhood specialists among midwives and gynaecologists and on how to strategically improve the supply chain which delivers Safe Motherhood as a commodity. In order to reduce maternal deaths WHO recommends the development of Safe Motherhood within strategic reproductive health plans which are suited to the specific needs of each country.

According to the WHO a quality and accessible safe motherhood should aim for the targets indicated in Table 1. The meeting of such targets should go a long way to reducing a country's maternal mortality rates.

[6] Child Survival Countdown to 2015, December 2005. Countdown to 2015 website. Tracking progress in Maternal, Newborn and Child Survival: Countdown to 2015- The 2008 Report. The Lancet: The Countdown to 2015 Issue - April 2008.

Table 1: Showing Safe Motherhood targets

Item	Number/percentage
Midwives	6 per Hospital 3 per PHC 2 per PHCU
Skilled attendants per 1,000 births	Should be 95%
Family planning	Should be 75%
ANC	Should be 100%
Clean /safe delivery	Should be 80%
Postnatal / New born Care	Should be 100%
Obstetric Care	Should be 100%

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

Safe Motherhood and gender-related issues

When it comes to issues of maternity, the majority of husbands do not understand much about pregnancy-related complications. Due to gender differences (Elizabeth *et al.*, 2002), men evade their responsibility where pregnancy is concerned. Pregnancy is a very expensive venture in life right from conception to delivery and the fact that it requires money and care causes men to fear and flee. Therefore, Safe Motherhood is more associated with women than the men. This explains why many countries like Uganda have initiated programmes for men to attend ANC sessions in order to promote their involvement in the delivery of Safe Motherhood. It is believed that for 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) the following needs to be done to make pregnancy safe:

- Advocacy to enlighten the public about the plight of pregnant women.
- Technical support for all the countries to support the Safe Motherhood initiative.
- Building partnerships between the medial and other sectors.
- Establish global standards for maternal health as well as norms to encourage the development of tools for addressing maternal mortality.
- Extensive on-going research to establish the causes and trends of maternal mortality.
- Establish international global monitoring and evaluation mechanisms.

Women worldwide experience lower socio-economic and legal status than men in the societies in which they live, whether inside prison or out. They generally suffer more deprivation and oppression than men and this creates inequality between them in all aspects of life. Society acknowledges that the death of a mother is a tragedy because it endangers the lives of their children and newborn babies both directly and indirectly.

The effects of Structural Adjustment Programmes (SAPs) on Safe Motherhood

According to de Brugn (Mutarika, 2003) the Structural Adjustment Programmes (SAPs) did not prove beneficial to the African countries which implemented them and the health of their populations declined by 39%. During this period most African governments spent less money on drugs and privatised their health care services. As a result, Safe Motherhood became expensive.

He argues that ‘one becomes pregnant freely without payment but in accessing pregnant service one has to pay for its unworthy life experience for women’. For example, some governments charge patients, including vulnerable women, user fees for their health services. As a result many women turn to TBAs who deliver free of charge rather than access Safe Motherhood. Currently, 67% women deliver in the hands of TBAs. This not only defeats the objectives of the Safe Motherhood initiative it also increases the risk of maternal mortality because many TBAs are unskilled in using the Safe Motherhood equipment which is calculated to prevent maternal deaths.

The Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa 2003 (the African Women's Rights Protocol or the Maputo Protocol) states that all state actors shall minimise the negative effects of globalization and effectively implement trade and economic policies and programmes to protect women against such negative impacts. Accordingly, South Sudan's Reproductive Policy, 2012 prioritized the promotion of Safe Motherhood in response to the country's high maternal mortality rate of 2,045/100,000.

Many authorities consider that the two vital human rights indicators which measure the effectiveness of the Safe Motherhood package to improve maternal health are financial access and physical access.[7]

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

- Absence of prenatal care.
- Lack of support both social and economic during and after pregnancy.
- And 3 types of delay i.e. the delay at home in seeking health care; the delay in transport in reaching the health facility and subsequently the delay in receiving treatment at the health facility.

Traditional Birth Attendants (TBAs) and the risk of death

Allow me to use the definition of a Ugandan PhD student as to what is meant by a TBA as it applies to my 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 Anderson, 2014).

[7] Health Policy of the Government of Southern Sudan, 2006-2011, 21.

Challenges faced by TBAs in the quest for Safe Motherhood

- 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 gynaecologist doctor to give specialized treatment.
- Factors associated with wrong diagnosis due to poor medical history taken by a TBA from the sources of referral centre has led to the wrong administration of treatment and procedure of diagnosis.
- Poor drugs supply chain management that usually results in the shortage of drugs and the stocking of expired drugs.
- TBAs have inadequate advanced skills that render useless specialised Safe Motherhood medical equipment.

Prenatal care is the most important aspect of Safe Motherhood as it involves the use of pantograph. It is estimated that 33% of maternal deaths occur due to the absence of prenatal care from pregnancy or child birth because most mother lack economic support to hire care or transport to access the nearest hospital. Studies have also revealed that women separated from their husbands, single and incarcerated women are most likely to die due to pregnancy-related complications as they lack social support. The study also revealed that accessibility is a common and increasingly worrying problem for pregnant women in prisons in developing countries.

Therefore in order to reduce maternal mortality rates easy access to good quality Safe Motherhood facilities are paramount and should be strongly supported wherever they are lacking. A mother-friendly community is one that offers a good transport network to Safe Motherhood facilities which have qualified nurses and well-equipped maternity wards. These are the essential qualities of sound and accessible Safe Motherhood services.

This study was carried out in Juba Main Prison (JMP) and its findings may or may not be reflective of other PHC, hospital or prison facilities whose conditions may be better or worse than those of JMP.

According to Tulisi Ram Bhandari (2014), a PhD scholar, global indicators on maternal mortality show that the causes of maternal mortality are mainly direct causes, i.e., haemorrhage (24%), eclampsia (12%), unsafe abortion (13%), obstructed labour (8%), sepsis (5%) and others (8% which include ectopic pregnancy, embolism and anaesthesia related causes) while indirect causes account for 20%, including, e.g., anaemia, TB, malaria, HIV/Aids, etc. This study confirms these causes of maternal deaths. Hence it ultimately advocates the need to invest comprehensively in fully accessible and good quality Safe Motherhood services in all health institutions and facilities throughout the country.

The Sustainable Development Goal (SDG) on Safe Motherhood (Goal 3)

- It aims achieving a healthy life for all as well as the promotion of all aspects of well-being of all citizens of all ages, regardless of sex, colour and gender.
- It supports all means possible to reduce the world's maternal mortality ratio to 70 for every 100,000 live births.
- By 2030 it aims to eradicate the global deaths of all newborns and children under 5 by reducing their mortality rate from 25 to 12 for every 1,000 live births.
- By 2030 it aims to provide Sexual Health Reproductive Services (SHRS, including family planning, information and education) as well as integrate SHRS strategic plan and programmes into maternal health (Safe Motherhood).
- It focuses on a comprehensive coverage of the health sector right from financial risk protection through to access to quality health care as well as affordability of all supplies of medical equipment, drugs, medicines and vaccines.
- It prioritises the financing of the health sector, employment, capacity-building and retention of well-trained health personnel in both developing and under-developed countries and small islands worldwide.

2.2 Human rights instruments

The UN Standard Minimum Rules for the Treatment of Prisoners (article 23. 1, 2) states that there shall be accommodation for women and their special needs while they are in custody and this shall include women with children; providing all necessary sanitary facilities to those who need them; providing space for mothers to nurse and breast feed their infants and assigning a senior prison warden to be in charge of such facilities.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) (article 12) advocates that all state actors take all necessary steps to ensure that everyone enjoys the highest physical and mental health attainable. Furthermore article 2 of the same Covenant also emphasizes that state parties act individually and with the help and co-operation of international bodies to realise the rights in question so as not to waste the state's available limited resources. This allows for the state to progressively realise the rights in question.

The International Covenant on Civil and Political Rights (ICCPR) (article 24(2)) requires that 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(2)(a) of the same Covenant requires that 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 pregnant women in custody deserve separate treatment to guarantee their basic human rights.

The Convention on the Elimination of All Forms of Discrimination against Women (article 12) requires all state parties to provide women adequate services when it come issues related to pregnancy, confinement and postnatal care of children. Hence incarcerated pregnant women should be given free suitable nutritional for their condition.

The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (principle 5(2)) requires that 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., pregnant women and those who are breast feeding infants, children (juveniles), the old, vulnerable, sick and disabled shall not be discriminated against hence the

need in such circumstances for all the conditions of a detainee's detention to be reviewed from time to time by law by the relevant authority.[8]

Human Rights Committee, General Comment 28 on the Equality of Rights between Men and Women

Women who are pregnant shall not be denied their personal liberty. Therefore they shall be accorded full humane treatment and their dignity honoured in terms of their constitutional and international rights especially during pregnancy, giving birth to and caring for their infants. All state parties should provide facilities that are necessary and adequate to meet the health requirements of both mother and child.

6th UN Congress on the Prevention of Crime and the Treatment of Offenders, Resolution 9, Specific Needs of Women Prisoners

It needs to be acknowledged and accepted that 80% of a woman's daily activities and responsibilities are dedicated to caring for their children. It should also be accepted that the impact of relocating a mother from her home and family to prison causes great psychological trauma. Therefore the UN and its NGO partners recommend that the imposition of an alternative sentence shall be considered when sentencing a mother, e.g., sentences involving community service. Even during the process of arrest, trial, sentence and imprisonment women who are pregnant shall be treated with fairness and equality because they encounter many problems 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'

It is recommended that as a tool for sentencing, imprisonment should not be imposed on certain groups of people/persons, e.g., pregnant women or mothers with infants because imprisonment of such persons is a sanction which should not be allowed to degenerate into a double sentence that causes more mental trauma to its victims.

The Committee on Economic, Social and Cultural Rights (Comment 14(3)) emphasized the importance of health rights, more specifically:

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[8] 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.

- The right to control one's health and body.
- The right to sexual and reproductive health.
- The right to freedom of choice of quality and good family planning.

Comment 14(4) elaborates on the requirement that government reduces the still birth and infant mortality rate and for the development of the state's health system.

Apart from the international instruments cited above, which constitute the basis of the right to health, several other regional and international conventions and treaties recognize this right. Below is a list of the main ones:

- 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);[9]
- 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);
- 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).

The United Nations Declaration on the Elimination of Violence against Women (article 2) provides that violence has a wide meaning and that physical sexual and psychological

[9] 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.

violence perpetrated or condoned by the state, wherever it occurs, in or outside prison shall not be tolerated. Article 4 provides that states shall not tolerate violence against women in any form and should not invoke any custom, tradition or religious consideration to avoid their obligation with respect to its elimination. Therefore states should immediately pursue all means possible to eliminate violence against women. Furthermore, states are required to take all measures to ensure that law enforcement officers and public officials who are implementing policies prevent, investigate and punish violence against women receiving correctional service.

The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (article 11) requires all states parties to make sure that penal systems are reviewed and all their rules, instructions, methods and practices are interrogated as one of the conditions 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) states that prisoners are to be kept differently and separately from each other taking into consideration the dynamics of their sex, age and criminal records. Young inmates are also to be kept separate from adults and in case of an institution that is intended for both men and women like a hospital there must be a separation between men and women. Institutions set aside for women should be under the responsibility of women officer who shall have the custody of the keys for the entire institution. Also no men are allowed to enter into such facilities unless in the company of a woman officer. Women prisoners must be attended to and supervised only by women officers; however this does not preclude male members of the staff's professional body (like doctors and teachers) from doing their professional jobs.

The United Nations Human Rights Committee, General Comment on article 17 of the International Covenant On Civil And Political Rights guarantees all persons the right to privacy. Its General Comment 16 on article 17 also provides that so far as personal and body searches are concerned, effective measures must be taken to ensure that such searches are carried out in a lawful manner with due consideration for personal dignity.

The United Nations Standard Minimum Rules For The Treatment Of Prisoners (rule 33) indicates that instruments of restraint such as handcuffs, chains, irons and strait-jackets

shall not be used as a punishment. It also provides that they shall not be used to restrain subjects except to prevent escape during transfer and must be removed when a prisoner appears before a judicial or administration authority.

The United Nations Standard Minimum Rules For The Treatment Of Prisoners (rule 27) permits the enforcement of order and discipline with firmness but with no more restriction than is necessary for the safe custody of inmates and a well–ordered community life but with due consideration to the needs of pregnant inmates. Rule 31 is all to do with corporal punishment and it prohibits various forms of cruel, inhuman or degrading treatment including the placing of prisoners in a dark cell. According to rule 32 punishment by closed confinement and the reduction of diet are never to be encouraged unless on medical grounds.

The Basic Principles For The Treatment Of Prisoners (principle 9) states that all prisoners shall have access to the health services available in the country without discrimination on the basis of sex or legal status. Principle 24 requires that maximum medical examination shall be offered to the detained or imprisoned persons as promptly as possible and whenever needed.

The United Nations Convention Against All Forms Of Discrimination Against Women (article 12) states that all states shall take measures to eliminate discrimination against women in the field of health care for basic access to health care services, including those related to family planning.

The United Nations Standard Minimum Rules For The Treatment Of Prisoners (article 24) requires that all medical officers shall see and examine every prisoner in order to ascertain the condition of their health while in prison and this must be done by a professional medical doctor.

Medical screening on entry is very important and as soon a prisoner arrives at a prison he/she must undergo a medical examination and health screen test to ensure that the prisoner is healthy and to 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 water which is necessary for the health of all inmates.

The European Prison Rules (2006) require the provision of all the sanitary requirements of women who are in incarceration.

The International Covenant on Economic, Social and Cultural Rights (article 10) states that special protection should be given to mothers during a reasonable period before and after child birth.

United Nations Convention Against All Forms of Discrimination Against Women (article 12) provides that all parties shall ensure that women are given without charge appropriate services in connection with pregnancy, confinement and the postnatal period.

The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (principle 5(2)) provides that any rights or special status attributed to women especially pregnant women and nursing mothers, children, juvenile aged, sick or handicapped person on account of their unique needs and interests shall not be deemed to be discriminatory.

The United Nations Standard Minimum Rules For The Treatment Of Prisoners (Rule 23(1)) provides that all women's institution shall be special equipped for all necessary pre-natal and post-natal care and treatment. It also provides that arrangements are to be made for women to deliver at the prison. According to rule 23(2), infants of women prisoners who are nursing them shall be allowed to remain in the institution with their mothers and there must be provision for such categories of people in prison.

In **General Comment 28, the Human Rights Committee** states that pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at all times especially during and after birth and while caring for their newborn children and it also requires states parties to report on facilities and medical and health care for imprisoned mothers and babies. It also accepts the **Council of European Parliamentary Assembly's Recommendation 1469 (2000)**, on mothers and babies in prison which was adopted on June 2000. In the view of the adverse effects of imprisonment of pregnant mothers and those with babies the Assembly recommends that the Committee of Ministers invite member states:

(i) to develop and use community-based penalties for mothers of young children and pregnant mothers to avoid the use of prison.

(ii) to develop education programmes for criminal justice professionals on the issue of mothers of 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 women convicted of the most serious offences and who present 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 is serious and violent and the woman continues to pose a 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 put 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.

2.3 Constitutional and legal issues

Transitional Constitution of South Sudan (TCSS) provides as follows:

> **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.
>
> **Rights of Women**
>
> Article 16(1)
>
> Women shall be accorded full and equal dignity of the person with men.

The Constitution is a source of harmony and tool through which culture is reorganised.

The South Sudan Prison Act, 2008 (SSPA) provides as follows:

> **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.
>
> (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.

Article 21 of South Sudan's National Policy states that all efforts shall be made to improve maternal health in all sectors especially that of reproductive health and safe motherhood in order to meet MGD 4.

CHAPTER THREE

3.0 RESEARCH METHODOLOGIES AND METHODS

3.1 Methodological approaches

3.1.1 Grounded theory

Safe motherhood is the most challenging condition that women face when in prison as most of their movement is curtailed by being confined in prison. Hence access to the Safe Motherhood package becomes problematic. Incarceration in particular makes the work of managing pregnancy very complex for women. Grounded theory was one of the investigative research tools I used to test the reliability of the research assumptions. This theory influenced my data collection methodology which involved collecting data, corroborating or adjusting my assumptions and, if necessary, further data collection. This was done during my visits to JMP, the Prison PHC and related NGOs.

During the collection process my theoretical assumptions started changing, especially the one stating that there is no access to Safe Motherhood had to be immediately adjusted and my definition of accessibility had to change because having a delivery ward without a bed does not signify an accessibility problem. The existence of health workers did not mean that they were Safe Motherhood personnel; it turned out that the health workers were actually TBA staff and not real midwives trained in Safe Motherhood practices.

I conducted examinations of both the delivery and the ANC wards for inmates. I used a check list approved by the WHO office in South Sudan to assess the standard of quality and the rights definition of access to Safe Motherhood as used by WHO, UNFPA and the World Bank. This included checking for the presence of equipment at the facility, the staff, the nurses in the ANC unit, the birth register and how records are kept and used. This involved interviews with the head and various heads of the departments at the prison's PHC.

I also conducted interviews with the inmates who were pregnant, other inmates who had given birth and were still at the prison and one inmate who had given birth and had since left the prison; prison wardens in charge of the female wards and prison wardens in charge of the prison PHC.

This methodology was evidence-based as women who were from the prison were able to explain their problems in their own words and suggest how a government intervention/s should be implemented to address them. The prison health workers were also interviewed in order to capture their views on the issues in question.

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 level within the Ministry of Health and the prison. In the first two months of the field research it was difficult to trace female inmates who were relocated Juba Main Hospital to give birth as it took too long for me to be cleared to conduct my research by the Ministry of Health Research Department of the Government of South Sudan (GOSS). The fact that my research was based on women's voices meant that I could immediately address the problems they were facing as well as those of the prison health workers. For example, we supplied pregnant mothers with the Mama Kits from the Reproductive Health Association of South Sudan (RHASS).

In the beginning it was difficult to get information from the PHC staff especially about their statistics, register and other records as they were not well organized. There were two female inmates who were pregnant and received better treatment than their fellow inmates because they were better off economically, more educated and asserted their rights. As a result, they enjoyed access to all services, including being escorted from the prison to a private hospital, Juba Complex Medical Care Centre, for ANC and this surprised me. The impression I got was that if all female inmates were educated like these two women, I think Safe Motherhood Services would be improved because women like these would push the government to meet their needs. Instead the majority of poor illiterate women prisoners are paying dearly for their illiteracy in that they are unaware of their rights as women, do not lobby for their rights and hence suffer from a lack of services and products, including pads and other important sanitary wear.

What also emerged was that as a result of a lack official security some were attacked. For example, after having been convicted and as they were waiting to be transported back to the Main Prison, two inmates were attacked by their complainants (victims of the inmates' crimes) at the court premises. As a result they suffered miscarriages and the attackers escaped without being punished by the court police.

3.1.2 Human rights based approach

The right to receive Safe Motherhood (maternal health) is a human right which is enshrined in various international treaties and instruments with which South Sudan is required to comply. It is the most recent country to join these treaties in its capacity as both a world member state and the 54th African state. South Sudan is known to have one of the worst human rights and humanitarian records in view of its history of conflict. For the purpose of this research it was important to investigate the human right to Safe Motherhood in the context of the human right to maternal health care, health and life.

It was imperative to find out whether the prison officials knew anything about the human rights of the female inmates in Juba Main Prison and the negative human rights reports on South Sudan in general in order to encourage them to respect the human rights of female inmates. The UN has proposed a transitional constitution and international human rights bodies for South Sudan. Although it turned out that the prison officials were aware of the basic fundamental human rights of these inmates, I found out that the South Sudan Juba Prison Female Inmate Prison was operating like a semi-open prison where inmates moved freely around the compound and cooked for themselves whatever food they could afford to buy. Therefore South Sudan is totally non-compliant with the international law in this respect. I found that female inmates knew about their human rights, but they lacked a channel through which they could make their voices heard to the prison authorities. It was very important to examine whether the Ministry was following the 1987 Safe Motherhood objectives and managed to achieve an indicator for MDG 5 during it is implementation period and vis-à-vis the new 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 the multi-sector approach that was adopted by Rwanda after the 1994 Rwandan war.

I also carried out interviews of the South Sudan Red Cross (SSRC) state co-ordinator and the health department as NGO handling health rights in prisons. Aids Resistant Trust (ART) is one of the NGOs. All those interviews were to find out what they do to inform female inmates about their maternal rights and to promote their maternal health rights in prison. However, the research showed that this NGO lacks monitoring and evaluation mechanisms. For example, 2014 South Sudan Red Cross SSRC donated a delivery bed but even by the time of this research in 2014 the bed has not been assembled as they lack technical staff and

tools for its assembly. An interviewed revealed that South Sudan acknowledged the donation of the delivery bed by an Italian assistant to South Sudan in 2014 but that project ended and as a result there are no funds for monitoring and evaluating the projects life cycle. That occurred a year ago.

3.1.3 The women's law approach (WLA)

The importance of this approach it is to inform and analyse the real experiences of women and, in this case, the pregnant women who live in the JMP prison and the issues pertaining to their lives and treatment while incarcerated.

In South Sudan things on paper look very positive including, for example, the fact that the Constitution requires that women enjoy 35% representation at all institutional levels. But the question is whether this is actually taking place in practice? 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 by 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 collection of the voices 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 that is used and whether or not it is operated in terms of the Prisons Act of 2008. By its nature, pregnancy is very hard and complex for women, but it is twice as hard for women who are pregnant and incarcerated as far as accessing the Safe Motherhood package (which includes family planning, ANC, clean and safe delivery and comprehensive obstetric care as well as postnatal care) is concerned. It does not take much to imagine the difficulties and fear involved for the typical woman when her labour pains begin in prison where there is no Mama Kit, no flowing water, no money, no clothing for the child, no soap and no stand-by ambulance to support her referral to Juba Main Hospital. It is not an exaggeration to say that the whole situation for such women is a nightmare and becoming life threatening..

3.1.4 The WHY approach

This approach helped me to investigate issues in detail when asking those in charge why situations were as they were and why things which should have been done were not being done, given that the law on paper is very clear black and white.

It helped me identify and fill in the gaps of the research. For example, given the main prison has a functional PHC, a delivery ward and an ANC ward, why is it not equipped with the required equipment? The explanation was that there was a lack of funds? And why is there a lack of funds? And I was told that funds had not been allocated for it in the budget by the finance department. And when I asked why this was the case, I was told that the finance department do no allocate funds to health because the priority is security not health.

When faced with a question that needed an answer I would just continue asking why until I found the answer. As a result of employing this approach I came across an unexpected reason from the prison authorities which explained why some of the Safe Motherhood packages are not in place despite the government's best efforts. This was a product of a journey of discovery that involved understanding and thinking about the entire health delivery system and its processes in South Sudan, including its relationship with various UN agencies.

This approach which involved identifying all the relevant facts from all the relevant actors (including the women prisoners) which gave rise to a particular problem and lay the ground for the finding of genuine helpful and shared solutions to the problem of the lack of Safe Motherhood at prison PHC.

It should be noted that I had to use the check list approved by the WHO South Sudan office to assess the quality of the Safe Motherhood package, e.g., quality of family planning, ANC, birth delivery and postnatal care. The answers to questions were not simply 'Yes' or 'No' but rather those who answered our questions were allowed to give their answers using their own language which were in turn translated to the researcher in simple Arabic. Incidentally, South Sudan has 64 different ethnic tribes and therefore there is a huge diversity of languages within the nation's population. Therefore, in the case of female inmates, every opportunity was given to them to express themselves freely without fear concerning their own prison experience. Recording every individual women inmate's suggestion allowed me to make genuine recommendations to improve the prison's delivery of Safe Motherhood.

3.2 Sample size and area of study

This research was carried out in Juba Main Prison, in Juba county central equatorial state, South Sudan. It was conducted on female inmates who were pregnant and those who had given birth at the prison facility as well as those who had visited the Juba Main Prison PHC for ANC. I was satisfied that this sample size was very representative in nature and provided valid information concerning the quality of and access to Safe Motherhood. Table 1 shows details of the 77 respondents interviewed from different groups, including women inmates, health workers, nurses and representatives of various NGOs.

Table 2: Showing details of the respondents interviewed

NO	CATEGORY/GROUP	RESPONDENTS' DETAILS	MALE	FEMALE
1	PRISON GROUPS	Pregnant women Mothers Youths who had not given birth Women with pregnancy-related complications		14 11 8 2
2	PRISON HEADS both health and non-health workers	Head of PHC Midwives TBAs	2	 6 4
3	NGO STAFF	SSRC ART RHASS	4 3	1 2 2
4	GOVERNMENT OFFICIAL	Head female prison Ministry of Health Prison wardens	 5 14	2
	TOTAL of 77 RESPONDENTS INTERVIEWED		25 MALES	52 FEMALES

3.3 Research tools

3.3.1 Tool one: Structured questionnaires

Structured questionnaires were developed to obtain data from the pregnant women who had accessed the Safe Motherhood package at Juba Main Prison more than twice. This was meant to collect data from the pregnant women to determine the nature and quality of the treatment they received when they sought to access the package.

3.3.2 Tool two: Focus group discussion (FGD) guides

Focus group discussion guides were developed and used to collect data from various focus groups (e.g., prison inmates, health workers) to find out their perception of the quality of care involved in the Safe Motherhood package under scrutiny.

3.3.3 Tool three: An interview guide and tape recorder

An interview guide was developed and used together with a tape recorder in the in-depth interviews. They were used to find out from the interviewees their opinions and what they considered were the facility's weaknesses and strengths and any possible solutions they could recommend to improve the facility.

3.3.4 Tool four: Check list

A check list was used from the scoring sheet for the yellow star assessment review to make observations. This was used to complete a basic list of the ideal requirements needed for the execution of Safe Motherhood and as a guideline to test the resources that were available.

3.4 Research Methods

3.4.1 Interviews

One-on-one interviews were carried out eventually after long struggle with the prison authorities due to their fear that the female inmates would expose their weaknesses which might have political repercussions for them. All the research was concerned about, however, was determining the quality and accessibility of Safe Motherhood to the female inmates at Juba Main Prison and Juba Main Hospital.

3.4.2 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. I observed

many things that were not told to me during interviews, e.g., I was able to observe that there was discrimination in the treatment of female inmates among the women themselves. I assessed delivery from the flow of mothers through the ward. I also observed Manual ANC being done by the prison TBAs. The free movement of female inmates was also observed within the prison fence.

CHAPTER FOUR

4.0 FINDINGS, DISCUSSION AND ANALYSIS

4.1 Introduction

This chapter presents the findings of the research which are concerned with the extent to which women inmates of Juba Main Prison access quality Safe Motherhood treatment for themselves and their newborns and the findings are presented under the following headings:

- Access to and quality of family planning
- Access to and quality of antenatal care
- Access to and quality of clean and safe delivery and postnatal care
- Access to and quality of comprehensive obstetric newborn care (CEMoNC)
- Why the government is failing to deliver on Safe Motherhood
- Juba Main Prison PHC Clinic
- Juba Main Hospital Maternity Clinic
- The Government's responses

South Sudan's maternal mortality rate is 2,045 for every 100,000 live births according to WHO (2014). This statistic alone made me conclude that one of my research assumptions should be that there are no Safe Motherhood facilities in South Sudan health institutions. In this study I seek to explain the story behind this statistic as most of the UNFP and WHO literature on South Sudan's maternal health is not accurate. If Safe Motherhood facilities are in existence and functioning (as they say it is), then all I needed to do was to investigate who is accessing it and the quality of the treatment they receive.[10]

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Since the colonial area not much has changed at the PHC of Juba Main Prison to improve its Safe Motherhood status. As a result the referral hospital is still Juba Main Hospital which is a few kilometres from the prison. Being the nation's main prison, Juba Main Prison's PHC is supposed to be more of a satellite PHC as many female inmates around South Sudan are

[10] http://www.cmmb.org/wp-content/uploads/2014/09/Juma-CCIH_Combining-Tradition-Technology-Safe-Motherhood-2014-06.do.

incarcerated there and it should include on its staff a fully qualified gynaecologist, midwives and nurses.

The female inmates Juba Main Prison are drawn from the following categories: there are those who are already pregnant when they are incarcerated and those who fall pregnant while they are in the process of getting bail and then become pregnant when they visit their homes. The prison should hold a maximum of 50 female inmates but due to a shortage of space it accommodates more than 177 inmates.

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4.2 Access to and quality of family planning

There was little or no information communicated by prison warders to women inmates on how they could avoid unintended pregnancies during the time their cases are pending in court. I noticed that the walls of the maternity ward were empty and did not contain any notices stressing the advantages and disadvantages of family planning which would help female inmates on how to manage this aspect of their lives. These notices need to be produced in both Arabic and English to initiate behavioural change communication (BCC) among the female inmates.

The training of service providers is needed to enhance technical skills and improve attitudes; need to be improved as recommended by WHO to at least to a skilled attendant instead of TBA. Juba Main Prison health workers especially those who work in the maternity ward are unskilled and most are TBAs. Therefore availability of skilled delivery is a signal of Safe Motherhood worldwide and the attendance of skilled attendants has a significantly improves Safe Motherhood treatment. Training up and maintaining skilled attendants also forms part of achieving MGD 5.

Guaranteeing the availability of family planning commodities and supplies at all levels of PHC is imperative. It should be noted that the Juba Main Prison does not have in place a supply chain management system which should monitor the inflow and outflow of contraceptives. At the time of compiling this report, no facility is available for providing family planning. This failure is serious in view of the fact that the institution accommodates women both above and below the age of reproduction age. Improvement of family planning

logistics management (LMIS/HMIS) is paramount for such an institution that treats more than 50 women every month.

The improvement of political and community support and participation in family planning activities at the prison needs to be addressed as it was found lacking. Although some political leaders do visit the female prison they only do so to observe its conditions, feeding facilities, hygiene, and accommodation. They seem to ignore life-threatening technical issues relating to Safe Motherhood.

There needs to be an improvement in record keeping. No register was kept showing the names of women inmates who were on or had been taken off family planning. It is estimated that due to the presence of the American Maristope NGO in South Sudan, about one quarter of women are enrolled on either one or more types of family planning in their life time.

There is an very urgent need to improve the follow-up, supervision and referral systems for the treatment of those female inmates whose contraceptives are due for removal because the JMP's PHC is totally ill-equipped for such treatment. Failure to attend to this urgent need will expose women to the danger of having expired contraceptives in their bodies and this is likely to cause them serious complications. Service points for providing family planning treatment of this kind need to be established throughout JMP to reach the entire female inmate population. The women are crying out for such attention, as evidenced by one female inmate:

> 'I am in trouble. I am seeing my monthly period every (on the) 11th (day) of a (the) month but l don't have pad to help myself with. If my relative brings (pads) for me I am lucky, (but) if not, I suffer. So I better insert a *jadal* to free (me) from all this. Imagine when I am on my period I don't go (outside) I stay inside for a week bearing all the pain.'

It should be noted that there are women who enter prison who already have such inserts implanted in them and they face the agonising problem of how, who, when and where to have them removed.

4.3 Access to and quality of antenatal care

Providing pregnant women with information, education and communication on the risk factors and warning signs and symptoms of possible complications during pregnancy through

the provision of ANC helps to prepare them both physically and mentally for pregnancy. It was found that JMP had made no adequate provision for this for its female inmates and therefore exposed them to the danger of complications during and after giving birth. It is a very complicated event. I was amazed that one female inmate who had been in prison for 3 months had failed to tell the prison authorities that she was pregnant. It was only during an FGD that she said admitted that she was indeed pregnant. She thought as any outsider I could offer her a good package. Compared to the prison manual ANC at the prison. Which she was not willing to attend to.

JMP does not have any means of preventing or managing anaemia. This is a serious oversight since anaemia is the main killer in pregnancy (WHO 2014). Since the prison does not have a proper feeding system in place, pregnant inmates suffer from micronutrient deficiencies which give rise to anaemia as they are forced to eat the same food as the rest of the inmates which comprises only of beans and *posho*. Pregnant inmates need to receive a diet which suits their nutritional needs.

Anaemia increases the risk of life-threatening complications including low birth weight, haemorrhages, sepsis and still birth. It is only those pregnant inmates who develop complications who receive treatment and may be referred to JMH for treatment. Those who are referred to in time to Juba Main Hospital with such complications are usually successfully treated with iron and folic acid supplements. The fact is that these supplements are essential for the normal development of a foetus. Therefore, if the prison health staff simply ensured that all pregnant inmates received such supplements all such anaemia-related complications could be prevented, meaning that referrals to JMH would no longer be required.

Screening for hypertension and diabetes is not being carried at the prison PHC, nor are the frequent examination of mothers to evaluate their pregnancies. Such tests are important because they help in the early detection of high risk pregnancies which may need to become the subject of referrals. Also, everything is manually done which means that most life-threatening risks are not detected early, thereby exposing female inmates to the risk of maternal death.

Immunization against tetanus was found to be conducted in JMP on a quarterly basis as required in terms of South Sudan’s National Health Policy, 2014. Syphilis screening and

treatment was also carried out and this exposed unborn babies to the risk of infection. The WHO (2014) estimated that the world is suffering of an annual infection rate of 500,000 for congenital syphilis. In an attempt to prevent the spreading of the disease, testing for syphilis is available at any given ANC facility and it can be treated with penicillin before the 16 weeks of any gestation.

HIV information, testing, treatment and referrals were carried out by NGOS and NGOs also gave ARVs for prevention of mother-to-child transmission of HIV. However the JMP's PHC has no testing reagent which exposes to infection not only the TBAs but also the pregnant inmates who in turn risk infecting their newborns during delivery. Therefore HIV pregnant women should always be treated by high level health professionals given their situation to avoid infecting the baby as well as the health worker. One TBA admitted being at risk given that they were told at a workshop about the danger but it was unfortunate that such services are missing and this exposes them to the aforementioned risk.

The prevention and management of malaria is done at JMP but there were some complaints. Malaria is a high risk contributor to infant mortality because it speeds up the rate and the risk of maternal anaemia which can result in problems of low newborn birth weight as well as premature births (i.e., miscarriages). However malaria is treatable by means of anti-malaria drugs. It can be prevented through the use of insecticide treated beds and nets. Although some of inmates have mosquito nets, cases of malaria still occur because their nets and rooms are not regularly sprayed.

It was found that the steps necessary to prepare for birth were not carried out at JMP. These steps enable a mother to be ready to face the birth of the foetus she is has been carrying for nine months and they involve the procurement of a Mama Kit, clothing for the newborn, deciding on the child's name, where and how to give birth, saving money (because in the last few months before delivery she may be so weakened and full of pain that she is not strong enough to work and generate an income to support herself), or the need to look for someone to support her in that time. Thus some birth provide preparedness package as guarantee of Safe Motherhood to a pregnant mother. The research found that immediately after giving birth, a mother is assigned two senior inmates to take care of her for a period of two weeks. I asked an inmate who cried during an FGD and she explained how desperate the situation is for pregnant woman giving birth in prison. She said:

> ‘I am imaging how my situation shall be if my time comes to delivery and am having nothings with me, only me and my God.’

While pregnant women should receive suitable male moral and economic support, this is not the case at JMP because men are only allowed to visit women inmates during visiting hours. This does not provide enough time for them to comfort traumatized mothers who are in such great need of care and counselling on issues including nutrition and infant feeding. Also the changes which may occur immediately after birth (e.g., change of homonyms within 24 hours after delivery) make such women vulnerable and especially needful of emotional comfort at such time.

4.4 Access to and quality of clean and safe delivery and postnatal care

Information on signs of labour, what to expect and what to do was done by TBAs at the PHC but there was no delivery form record or check list of what to do during the delivery process. For example, one of the prison TBAs explained:

> ‘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 means that when a mother needs to be referred to a more experienced health worker (e.g., gynaecologist), the TBA (who has made no written record of the history of the delivery process) has to explain this whole process to them. This is unacceptable and requires a new and much better procedure. The worst case scenario is when a delivering mother is unconscious and cannot therefore explain what might be the cause of her prolonged labour. Hence, this exposes mothers to danger. Monitoring labour and documenting what needs to be done and has been properly done is important. If these steps are not taken problems may arise when it comes to having to refer a mother to another health worker or facility.

It was only during collecting data for this study was it discovered that no deliveries are taking place at the JMP PHC and all deliveries are being referred to Juba Main Hospital. It is questionable whether this practice is sustainable given the current economic crisis in South Sudan in which there is sometimes no fuel in the capital city for transportation.

Clean supplies and drugs required for pain relief and delivery are given to the women inmates but when there is a shortage, their relatives have to buy such provisions from private clinics and the prison authorities contact members of the inmates' families, especially their spouses, for this purpose. HIV testing and counselling are also not carried out at the JMP PHC and this therefore remains a challenge which needs to be addressed along with counselling on recommended infant feeding options.

Postnatal care and newborn care

During the data collection process for this research, the flowing important aspects of postnatal care and newborn care were also found lacking in quality:

- Information on danger signs, what to expect and what to do is always done by one of the pregnant inmate's more experienced fellow inmates. This type of care lacks quality as it is 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 infections that may result from complications during and after birth.
- Counselling on infant feeding options is not done. This is a very necessary requirement because it prepares the mother's mind on how to handle the pregnancy and how to accept some of the changes brought about by pregnancy. It also builds the mother's confidence. She needs to be encouraged that despite all that she is going through, there is the positive hope that she will be restored to full health.
- Maternal wellbeing. Nutrition for the pregnant mother and her workload is assessed on an individual basis. Pregnant mothers need to be given a balanced diet and be supplemented with vitamins A, B and C as well as other important foods for the healthy development of the foetus. A lack of any of these valuable nutritious foods for mothers is most likely to result in the malformation of the child in the womb.
- Responsible fatherhood is absent. Fathers/spouses give psychological support to their partners/spouses and when incarceration separates them,

this causes mothers to suffer from mental trauma which affects their mental well-being.

- Family planning options are not provided. Family planning programmes are lacking in most of the country. Women are not given adequate choices as to what kind of family planning is most suitable for them in order to avoid unintended pregnancy. Women in prison are neglected, survive by God's mercy and sometimes fall pregnant during the time they battle their cases through the legal system.
- Counselling on when it is safe to resume sex is not provided. After delivering in prison, most women are not educated about when it is safe to resume sex and they end up falling pregnant unintentionally. Many of them complain about this problem said that it is difficult for them to control their bodies.
- Treatment at the postnatal clinic is only available for 6 weeks after delivery. Postnatal treatment is very important for mothers who have just delivered especial for the first 24 weeks because most maternal deaths are recorded within this period. During this period reviews are done to monitor how a mother is coping and the health of the baby. The absence of such facilities exposes the mothers at the prison to the danger of the complications which are more fully explained in chapter two of this research.

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

Since I defined 'access' earlier to mean the right to fully utilise a given facility, I would conclude that given the absence of many items which constitute Safe Motherhood, the nearby facility is become inaccessible despite it being few metres away from the given location. Concerning the issue of affordability, I have also taken into consideration whether the poor women are able to afford to pay for some of these items and pay the user fees. Female inmates who have complications during labour are not referred to the Juba Main Hospital in time. When they are referred in time, sometimes there are delays depending on the individual women involved.

Safe Motherhood accessibility is problematic in the following areas:

- Accessing antenatal clinic (ANC).
- Immunization and vaccination of mother and baby.
- Lack of adequate money to procure materials (such as Mama Kits) as pregnancy is a very expensive venture.
- Capacity to avoid the 3 types of *delay*, i.e., the *delay* at the prison in its decision whether or not to take a pregnant inmate to the clinic; the *delay* in finding transport to transport her to the clinic, the *delay* before she receives treatment at the medical facility.
- Lack of pantographic.

Pregnant women inmates of Juba Main Prison are able to give birth to their newborns at the facilities indicated in Table 3.

Table 3: Showing details of facilities which provide delivery services to pregnant women inmates of Juba Main Prison

Facility providing delivery services	Number of institutions
Juba Main Hospital	1
PHC	4
NGO/Private	16
Total	21

4.5 Access to and quality of comprehensive obstetric newborn care (CEMoNC)

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 functions of maternal health at the facilities (see Table 4).

Table 4: Showing ratings of signal functions which test the quality of comprehensive obstetric newborn care (CEMoNC)

Signal function	Percentages
1. Parenteral antibiotics	44 % out of 100
2. Parenteral oxytocic	39% out of 100
3. Parenteral anti-convulsants	31.5% out of 100
4. Manual removal of placenta	35.5% out 100
5. Removal of retained product	15% out of 100
6. Assisted vaginal delivery	7% out of 100
7. Newborn resuscitation	27 % out of 100
8. Blood transfusion	34 % out of 100
9. Surgery/Caesarean section	34% out of 100
	Total 240 out of 900 (which is very low compared to the WHO minimum requirement of 550-600 out of 900)

(Source: Juba Main Hospital, 2014)

(1) Administration of parenteral antibiotics to 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. This is a positive indicator of quality and access to Safe Motherhood as seen from the data obtained from the Juba Main Hospital.

(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. Table 5 shows the uterotonic drugs administered to women at Juba Main Hospital and certain other facilities.

Table 5: Showing uterotonic drugs administered to women at certain facilities

Facility	Drugs administered	Percentage
Juba Main Hospital	Ergomentrine	22%
Private	Ergomentrine	5%
NGOs/Religious	Ergomentrine	17%
Total		44% out of 100

(Source: Ministry of Health, GOSS)

(3) Administration of parenteral anti-convulsants for pre-eclampsia and eclampsia, e.g., magnesium sulphate

As the result of poor management of the delivery process pre-eclampsia and eclampsia are the most frequent cause of morbidities of pregnant women in South Sudan. It can be prevented and treated using parenteral anti-convulsants, like magnesium sulphate, Diazepam. Table 6 shows the administration of parenteral anti-convulsants at Juba Main Hospital and certain other facilities.

Table 6: Showing the administration of parenteral anti-convulsants at certain facilities

Facilities	Percentage	Drugs 1	Drugs 2	Both
Juba Main Hospital	6%	Magnesium sulphate	Diazepam	Both
Private	33%	Magnesium sulphate		One only
NGO/ Religious	11%	Magnesium sulphate		One only
Total	50% out of 100 which is fairly good			

(4) Removal of placenta manually

and

(5) Removal of retained substances by, e.g., manual vacuum extraction, dilatation and curettage

Removal of all retained substances or products from a mother is the most important aspect of quality of Safe Motherhood. If the majority of this retained product is not removed it can cause complications that may result in maternal death. Removal is done through D&C and curettage or E&C. Note that the facilities in Table 7 examined for their removal of retained substances all enjoy hospital level status, and include Juba Complex Hospital, Juba Main Hospital, UN agencies and Usuratuna Catholic Hospital which run clinical services which provide this treatment to inmates.

Table 7: Showing the removal of retained substances after delivery at certain facilites

Facilities	Percentage	Method	
Juba Main Hospital	15%	MVA and Curettage	D&C or E&C
Private	5%	Yes	Yes
NGO/Religious	7%	Yes	Yes
Total	27%	Yes	Yes

(6) Performance of assisted vaginal delivery, e.g., vacuum extraction

It was found that Assisted Vaginal Delivery (AVD) was not done in Juba Main Hospital. When asked why they could not perform this procedure the authorities cited a lack of training and lack of drugs and equipment. Except from private and NGO/religious health institutions making it the lowest performed signal function of Safe Motherhood. Most of the facilities used only a vacuum extractor (e.g., at the private hospital, Juba Complex) while NGOs and religious health institutions prefer using a vacuum extractor and obstetric forceps.

(7) Performance of neonatal resuscitation, e.g., with bag and mask (1-7)

Although the equipment for this procedure is available at the Prison PHC it cannot be used by the staff because they lack the expertise to do so. However resuscitation equipment such as a 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. Although there was an ambu bag it was not being used due to a lack of training as to 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 measure for promoting Safe Motherhood.

(8) Performance of blood transfusion

Blood transfusions are possible provided the pregnant inmate has a relative (e.g., husband, brother or sister) or someone they can hire to help who can donate blood in exchange for blood that needs to be given to the inmate.

However the experience is different at the private hospital where the patient has to pay for the blood at the rate of 70 South Sudanese Pound (SSP) per litre. NGOs, however, give free blood transfusions but the challenge is that they do not have a refrigerator big enough to store enough blood. Hence they are always vulnerable to blood shortages as they depend on their suppliers in Nairobi, Kenya and Kampala, Uganda.

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, poor inmates who cannot afford such facilities of service are exposed to suffer as they cannot pay due to their poverty.

(9) Performance of surgery, e.g. caesarean section

I concentrated on the three most recent females who had undergone a caesarean delivery and had been successfully discharged in the previous 6 months, two of whom had been discharged from Juba Main Hospital (government) and one from Juba Complex (private). I found out their condition upon discharge after reading through their history request, case history and medical history. Though the operation were comprehensive after time for recovering, i.e., bed rest was limited for the inmates as they were forced to return to their prison cells and to get some of the medication they needed from JMP PHC which is poorly

equipped and this is clearly a challenge as this often forces inmates to buy medical supplies from private clinics.

4.6 Why the government is failing to deliver on Safe Motherhood

South Sudan's failure to comply with the Safe Motherhood package in the prison is due to the complexities of all plural legal mechanisms that are in place posing a serious 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 compliancy 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 SalvaKiir, Washington, DC, December 2011).

The continuing conflict in South Sudan also undermines efforts to comply with the international policy for Safe Motherhood initiatives 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 policies that can be used to comply with international obligations and most of its policies are still in the developmental process and exist in the form of Bills of Parliament hence this curtails its compliance with international laws. South Sudan still lacks the technical personnel (endowed with a sound health and legal background) required to comply with the international laws.

Unlike Rwanda, South Sudan does not adopt a multi-sector approach when addressing its post-conflict developmental problems. For example, in Rwanda after its 1994 conflict, all of its ministries worked together to rebuild the country. For example, the Ministry of Health worked together with the Ministry of Education in its efforts to build and improve its human resources; it worked with the Ministry of Agriculture to solve the country's nutritional

problems; it worked with its Ministry of Foreign Affairs to attract donors to invest in its health sector; it worked with its Justice Ministry to assist in making health laws which meant that it was easier for the country to comply with international treaties in the shortest possible period of time after its conflict. Despite the challenges faced by South Sudan's prison service in its delivery of Safe Motherhood to its female inmates, however, the country's Prison Commissioner is aware of its constitutional obligations and has been quoted as saying:

> '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).

It follows therefore that since justice, equality and respect for human dignity are fundamental international human rights, South Sudan should honour and comply with her obligations to pregnant female inmates both internationally and nationally in terms of her Transitional Constitution.

It has been acknowledged that since South Sudan automatically inherited her international obligations from Sudan after gaining her Independence in 2011, she is bound to comply with her international obligations under various international human rights instruments, including 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), and the African Charter on Human and Peoples' and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

4.7 Juba Main Prison PHC Clinic

Juba Main Prison PHC Clinic is located within Juba Main Prison and has the following departments: the Midwives Department, Nursing Laboratory and Administration. It is headed by a Medical Assistant with a visiting doctor. The building has 8 rooms with a small out-patients department (OPD). It contains two admission wards, one for females and one for males, and each contains 8 beds. It offers treatment at the primary health care (PHC) level.

The clinic carries out ANC and deliveries but does not provide emergency obstetric services to its female inmates. It is facing some challenges including: no fresh flowing water, no

power, no delivery bed, poor staff working conditions, no adequately qualified technical medical team and it also suffers a serious under-funding problem from central government in order to meet all the clinic's running maternal costs.

Then there is the problem of delays which take place in the process of managing complicated deliveries. The first delay is caused as a result of the lack of technical knowledge on the part of the prison TBAs in detecting and assessing some of the danger signs of a problematic delivery. The second delay arises from the fact that the prison PHC has no communication equipment or cell phone and no transport to move inmates to a suitable health facility (like Juba Main Hospital) to perform a delivery and the inmates do not have money to hire a vehicle. The third delay sometimes occurs at Juba Main Hospital which may have no doctor on duty or no senior midwives to attend to the inmates and/or do not have the drugs to treat them.

4.8 Juba Main Hospital Maternity Clinic

Juba Main Hospital is a national hospital that receives referrals from all over the country. It handles more than 50 mothers per day and the facility is too small to serve the growing population. For example, Figure 6 is a photograph of patients in the waiting area of the maternity OPD of Juba Main Hospital. Although the women who are in prison are sheltered from the insecurity that the country is undergoing, whether they are free or in prison they still lack the security they should enjoy surrounding pregnancy and motherhood as the same dangers facing them outside prison, follow them into prison and harm or kill them. For example, women inmates are still vulnerable to infections (from puerperal fever and retained placenta), haemorrhaging, or obstructed birth. One of them said:

> 'The hospital is mainly supplied 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 great need of blood transfusion.'

Table 8 gives details of the women offenders at Juba Main Prison who are on remand (bail) and those who have been convicted.

Figure 6: Photograph of patients in the waiting area of the maternity OPD of Juba Main Hospital

Table 8: Showing categories of offenders who are on remand (bail) and those who have been convicted

CRIME	NUMBER	PERCENTAGE
Murder	6	4.8%
Theft	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 is estimated that well-trained midwives or skilled attendants can prevent the deaths of mothers in a given country by up to 90% according to UNFPA's statistics for maternal mortalities in South Sudan for 2014. Their role is paramount right from conception during ANC up to the time of delivery. One senior medical official said Juba Main Hospital does not have enough drugs or well-trained staff despite it being a national referral centre. Only 3 registered midwives manage the overcrowded maternity ward which conducts all maternity consultations and procedures. One of the midwives said:

> 'We are only two on duty and a lot of the women number are increasing and remember we only have 8 beds only; the rest are broken down for both labour and post-natal mothers.'

According to UNFPA's 2014 report on the assessment of South Sudan's maternal human sources it recorded that the country has only 8 registered midwives and 150 community midwives for the whole country. Many analysts state that the conditions of the prison PHC are no different from those at the Juba Main Hospital and that the difference between them lies merely in name, meaning, this one is a PHC and the other is a hospital.

One professional lamented that TBAs are not helping in preventing maternal deaths in this hospital; instead they are making it worse, e.g., if the mother has post-partum haemorrhage they are in no position to help; hence, birth delivery here is a lottery, especially if a mother's labour begins at night.

Midwives are considered the backbone of reducing maternal mortality. They do not use pantgraphy 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 colleagues from the prison PHC to send us these mothers early enough so that we are able to help them'
> (Abdala, the doctor in charge of the maternity department).

4.9 The Government's responses

While South Sudan's National Health Policy 2012 has banned the employment of TBAs, the country's lack of medical personnel means that the implementation of this policy remains only an undertaking on paper. Based on the reality that prevails in South Sudan there is no option but to keep the TBAs. The community used to rely on these TBAs and they do in fact draw enjoy support from the community as well the government. During the civil war most of the births were conducted by TBAs in most parts of South Sudan. The Ministry of Health should use donor support to try to train as many midwives as possible. But the question remains as to when this gap will be filled by the Ministry.

The government is mobilizing more resources ranging from financial to other forms of material support to offer comprehensive and quality Safe Motherhood to all women citizens in South Sudan especially those within the prison system through ensuring a judicious and sensible use of health resources so that the best value is derived from them.

The development of a well-equipped maternal data base for information concerning the health system for Safe Motherhood is a priority because it updates the national Ministry of Health as it improves Safe Motherhood.

Through the Directorate of Research in the Ministry of Health, the government has improved its focus by doing more research in the area of Safe Motherhood in a bid to improve health and identify the most challenging issues facing maternal health in South Sudan and thereby reduce its high maternal mortality rate. Research will set the objectives, evaluation and strategies planning of policy.

The government of South Sudan is also working at:

- Implementing and initiating a reproductive health regulatory monitoring framework. This will ensure that the best professionals and ethical practices in the delivery of Safe Motherhood are developed in South Sudan through adopting the best health care practices from countries that have performed best in maternal health, particularly in Safe Motherhood. The

reason for this is that ensuring quality Safe Motherhood delivery in South Sudan is its main objective.

- Increasing both the numbers of health care experts and improving their skills in order to close the gap of inadequate manpower within its reproductive health services so that they run efficiently and effectively at every level of the country's health care system.

- Establishing a good number of adequately equipped PHC to capably offer basic and comprehensive obstetric care to mothers in various parts of the country.

- Guaranteeing free access to quality Safe Motherhood services to all South Sudanese mothers in order to reduce the country's high maternal mortality rate.

- Putting in place all possible measures to eradicate all forms gender-based discrimination in South Sudan as advocated by CEDAW and to create equality in health care that will promote the dignity of all citizens of both sexes.

- Establishing capacity building initiatives within the hospital for training under-qualified staff on the job training for the effective diagnosis of problems and management of treatment with same staff deployed outside the hospital especially to the PHC. This will bridge the gynaecological gaps in the PHC. The government's intention to make comprehensive reproductive health care accessible in prison for all inmates throughout South Sudan, irrespective of their sex, gender or tribe.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Throughout my research, it has clearly emerged that despite having both inherited and having become a signatory to many international human rights treaties (including the ICCPR and CEDAW), the Government of South Sudan (GOSS) is completely failing to provide women in prison with effective access to Safe Motherhood, despite the United Nations Mission in South Sudan (UNMISS) working side by side in capacity building efforts with all of South Sudan's various Government Ministries.

The rights that the GOSS promises and guarantees its citizens from its Transitional Constitution to its national and national health policies all sound very positive especially those concerning maternal health which are a major concern of the Ministry of Health. However, South Sudan's high maternal mortality rate of 2,045 for every 100,000 live births is a clear indicator that the government's delivery of what it has promised is less satisfactory. In other words, the government has not done enough work in the area of Safe Motherhood and the poor conditions of its delivery of this service in the PHC of Juba Main Prison is clear evidence of this fact.

One of the main weaknesses of the services offered by Juba Prison and Juba Main Hospital is their employment of TBAs who are insufficiently qualified to conduct Safe Motherhood practices which would help reduce the maternal mortality rate. The WHO declared TABs unqualified to perform the much needed work of skilled birth attendants. Since its Independence in 2011 and even as far back as 2005, the GOSS has made no great effort to construct or even renovate the Health Centre in an effort to promote the 1987 Nairobi Safe Motherhood initiative for the people of South Sudan. Despite all the support it has received from the global community and its 15 year implementation plan, South Sudan has still been unable to achieve its Millennium Development Goals Numbers 4 and 5.

In addition, the medical personnel at both Juba Main Hospital and Juba Main Prison lack the critical support of a reliable drugs supply chain and equipment (like a pantograph, auto-sound equipment, etc.,) which make up the maternal aspects of the Safe Motherhood package and

which guarantee safe pregnancy and delivery. As a result of these weaknesses women and children continue dying at the hands of medical personnel who are supposed to save lives in these medical facilities. Therefore I am calling for the following:

- Educate female inmates concerning their right to access quality Safe Motherhood treatment and how to lobby for it.

- Include all female inmates in the right to access quality Safe Motherhood treatment in order to minimise and ultimately eliminate all forms of discrimination between women prisoners which will help reduce the maternal mortality rate.

- Improve mechanisms to hold the government and NGOs accountable in their work to reduce maternal death rates.

5.2 Recommendations

While South Sudan inherited its obligations under various international treaties at Independence, it is now an independent country and therefore needs to sign and ratify all international treaties to which it is bound and guarantee the right of its citizens to sue the state. It is also mandatory for South Sudan to domesticate such treaties 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 Sudanese Parliament and South Sudan's Ministry of Justice within the East African block to put some of these laws into place because Sudan was a member of these treaties. South Sudan must also create its own law enforcement task force to ensure that all mothers deliver in a healthy environment whether or not they are in prison.

Sufficient funds should be allocated to the Ministry of Health's budget so that the GOSS will be able to meet the maternal health targets of its national health policy. Policy also needs to be translated into legislation which incorporates the nation's obligations under various

relevant international treaties. Health rights, including maternal health rights, also need to be protected by making them justiciable meaning that citizens may enforce them through all the courts in the land.

South Sudan's Health Pool Fund (HPF) should concentrate its efforts at improving the delivery of Safe Motherhood in order to achieve its missed Millennium Development Goal Number 5 as well as Sustainable Development Goal (SDG) 2030 Agenda Number 3. It is time for South Sudan to adjust its strategic planning so as to align itself with the rest of the world in reducing the global maternal mortality rate.

There is a need for South Sudan to adopt fully the Campaign on the Accelerated Reduction of Maternal Mortality (CARMMA) in its health policy. CARMMA is focused on providing basic maternal services to improve maternal health in Africa. This involves international co-ordination between countries with high maternal mortality rates which adopt the best practices of those countries who have managed to lower their maternal rates. CARMMA's core values are based on Africanism and embrace issues such as promoting and protecting women's health and sexual rights, pursuing gender equality and economic empowerment, considering the impact of armed conflicts on health, opposing early marriages and other abuses and providing all citizens with comprehensive health and sex education. Ultimately, it will be through providing a comprehensive Sexual Reproductive Health Service (SRHS) to all citizens of South Sudan that women will finally gain control over their own bodies. In the process harmful African cultural practices against women may be eradicated.

Therefore South Sudan should adopt the overall of objective of Safe Motherhood that states that no mother or child should be harmed during pregnancy or after birth. This objective should be adopted at every level of implementation of the government's maternal health policy.

This research found that malaria during pregnancy among prison inmates was identified as the most frequent cause of pregnancy related complications. Therefore since malaria is such a significant national problem, the Government should protect all inmates nationwide from the disease by providing them with insecticide treated mosquito nets.

The GOSS should set up a joint task force between its Ministry of Health and Interior Ministry to make a full assessment of the health condition and needs of female inmates, and come up with a join recommendation to handle the issues facing female inmates. A prison health task force should be established to oversee the health condition and needs of pregnant inmates and make recommendations to both Ministries concerning the full implementation of Safe Motherhood in all prisons accommodating women in South Sudan.

All TBAs should be trained in Safe Motherhood care as they have huge experience in maternal health education. They ought to be given choice to stay and be trained to become qualified midwives by the Ministries of Health and Education. This is based on the research which has shown that in the short term, South Sudan cannot do without TBAs given the current health personnel shortage facing the country. The GOSS should also make policy that recognises, supports and protects TBAs as they continue to execute their duties throughout the country without fear of exploitation, persecution or abuse.

The Prison Act should allow for the recruitment of a professional gynaecologist and midwives in prison institutions so that a permanent body of professionals exists within the prison system as to implement maternal health. If this is not possible, courses should be made available for existing young officers to attend educational training in this area. This will help resolve the critical lack of medical personnel in all prisons.

To reduce or avoid the 3 types of delay referred to in this research, the PHC authority should partner with NGO or UN agencies to acquire an ambulance to help pregnant inmates as they cannot hire a car to transport them to the nearest health facility. This ambulance could take the form of a motor vehicle or a motor cycle. Figure 7 is a photograph of a motor cycle ambulance already in use in some parts of the country. Pregnant inmates have to be given adequate maternal education so as to avoid decision making of how and where to give birth during this ANC secession.

Figure 7: Photograph of a motor cycle ambulance used in some parts of Western Equator Ezo County, South Sudan

(Source: Combining Tradition and Technology for Safe Motherhood: Success with TBAs in Bridging the Human Resource Gap in the very resource limited emergency setting of South Sudan)

The government should focus on the reduction of maternal mortality by targeting PHCs, like Juba Main Prison PHC, where hidden births take place among the most vulnerable and least protected citizens in South Sudan. The government can achieve this by fully supporting the development and implementation of all health policies at all prison health facilities. Such action will protect and promote all the human rights of the prisoners and most critically provide access to health facilities to mothers, their newborns and infants of less than 5 years of age. The GOSS also needs to set up fully comprehensive obstetric services at the prison PHC.

Finally, the following is a list of specific areas in which the GOSS needs to concentrate its efforts and resources to strengthen its entire health delivery system:

- 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
- Co-ordination, Communication and Networking
- Pharmaceuticals and Medical Supplies
- Traditional/Herbal Medicine
- Information Technology and Communications
- Procurement and Logistics
- Health System Research

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