ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: SOUTH SUDAN

OCTOBER 2016

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Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc. in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

Recommended Citation
Kristen Devlin, Susan Higman, Kimberly Farnham Egan, and Tanvi Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: South Sudan*. Arlington, VA: Advancing Partners & Communities.

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ACRONYMS

APC	Advancing Partners & Communities
BHC	boma health committee
BPHNS	Basic Package for Health and Nutrition Services
CHD	county health department
CHS	community health system
CHW	community health worker
CMHT	county health management team
CMW	community midwife
FP	family planning
HHP	home health promoter
HSDP	Health Sector Development Plan
IUD	intrauterine device
MCHW	maternal and child health worker
MOH	Ministry of Health
NGO	nongovernmental organization
PHCC	primary health care center
PHCU	primary health care unit
SMOH	state ministry of health
TB	tuberculosis
TBA	traditional birth attendant
USAID	United States Agency for International Development
VHC	village health committee
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each country as appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

SOUTH SUDAN COMMUNITY HEALTH OVERVIEW

In 2005, following decades of a devastating war that resulted in millions dying and being displaced by famine, disease, and conflict, a peace treaty providing autonomy to southern Sudan was signed. Six years later, in 2011, the region achieved full national independence and became the Republic of South Sudan. Today, however, the country still faces ongoing political unrest, weak infrastructure, and poor delivery of health services.

Despite these challenges, South Sudan has taken steps to establish and strengthen its health system. Beginning in 2005, the Southern Sudanese government embarked on a mission to set up and regulate health service delivery with an emphasis on community health and created policies promoting the right to health, equity, poverty reduction, community ownership, and good governance.

Official independence in 2011 provided South Sudan with new opportunities to address the health needs of the country's population. Originally developed in 2009 and updated in 2011, the *Basic Package of Health and Nutrition Services (BPHNS)* outlines the essential health service package for primary and secondary health care. The document emphasizes community infrastructure, a continuum of care for service delivery, and links health services with other sectors, such as agriculture, education, environmental management, and gender.

The Ministry of Health (MOH) also developed an overarching health strategy, the *Health Sector Development Plan 2012–2016 (HSDP)*, for which the objectives are to:

1. Increase use and quality of health services, with emphasis on maternal and child health.
2. Scale up health promotion and protection interventions that encourage communities to take charge of their health.
3. Strengthen institutional functioning including governance and health system effectiveness, efficiency, and equity.

The *HSDP* summarizes many of the health challenges that South Sudan faces, such as underdeveloped infrastructure and a high disease burden, and identifies critical conditions for attaining health objectives, like the need for adequate human resources for health and for improved accessibility of health services. The country's *Policy Framework (2013–2016)* is aligned with the *HSDP* and further defines the key policies and priorities South Sudan needs to reach its health goals. Additional policies provide guidance for specific health areas (e.g., for reproductive health, FP, and HIV), including at the community level.

Policy guidance for community health in South Sudan is not always clear or comprehensive. This may be because some policies and strategies were developed at a time when it was an autonomous region (2005-2011), while others were developed after the country achieved full independence (2011 onward). Moreover, the country's ongoing instability and involvement of multiple stakeholders has created a complex working environment for coordination, delineation of respective roles, and fragmented planning and implementation. Despite these complexities, this profile attempts to describe South Sudan's community health system per available policy guidance as accurately and comprehensively as possible.

South Sudan's policies mention five main cadres of community health providers. Community health workers (CHWs) and maternal and child health workers (MCHWs) provide services from health facilities, which include primary health care units (PHCUs) and primary health care centers (PHCCs) – though CHWs may also work in communities. CHWs focus on general provision of primary health

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Basic Package of Health and Nutrition Services (BPHNS)*		*Health Sector Development Plan (2012–2016) (HSDP)*	*Policy Framework (2013–2016)*	
Last updated	2011		2012	2013	
Number of community health provider cadres	5 main cadres				
	Community health workers (CHWs)	Community midwives (CMWs)	Home health promoters (HHPs)	Maternal and child health workers (MCHWs)	Traditional birth attendants (TBAs)
Recommended number of community health providers	1,600–2,152 CHWs[1]	408–568 CMWs[1]	*Information not available in policy*	1,218–1,584 MCHWs[1]	*Information not available in policy*[2]
Estimated number of community health providers	At least 1,894 CHWs and MCHWs combined[3]	96 CMWs[3]	*Information not available in policy*	At least 1,894 CHWs and MCHWs combined[3]	*Information not available in policy*
Recommended ratio of community health providers to beneficiaries	2 CHWs : 1 community-level health facility[4]	1–2 CMWs : 1 community-level health facility[4]	1 HHP : 20–50 households[5]	2 MCHWs : 1 PHCU	Approximately 1 TBA : 1 village
Community-level data collection	Yes				
Levels of management of community-level service delivery	National, state, county, community (payam, boma, village)				
Key community health program(s)	Various community health programs aligned under the primary health care service delivery system				

[1] Rough calculation based on a) approximately 609–792 PHCUs and 204–284 PHCCs in the country, given varying estimates; and b) an ideal number of approximately 2 CHWs per health facility (PHCU and PHCC), an ideal number of 2 MCHWs per PHCU, and an ideal number of 1 CMW per PHCU or 2 CMWs per PHCC. There is contradictory information in the *BPHNS* about this.

[2] Policy indicates that the MOHS is trying to phase out TBAs, instead training them as professional midwives to conduct deliveries. It may also recruit them for other roles, such as CHWs and HHPs.

[3] According to South Sudan's *National Reproductive Health Policy*, as of 2011, there was a total of 1,894 CHWs and MCHWs (combined) and 96 CMWs trained in reproductive health. However, separate NGO documentation indicates over 4,000 CHWs in 2011, though it does not specify how this cadre was defined.

[4] Refers to either a PHCU, which covers approximately 15,000 people, or a PHCC, which covers approximately 50,000 people.

[5] Corresponds to approximately 134–335 people. However, policy also indicates that this is general guidance, and that communities should decide the coverage area themselves.

care services while MCHWs specialize in maternal and child health. Community midwives (CMWs) are a newer, facility-based cadre trained in safe delivery; however, policies are contradictory about whether CMWs should complement or replace other cadres, such as traditional birth attendants (TBAs). Home health promoters (HHPs) work in communities and collaborate with other cadres to facilitate service provision and conduct health awareness-raising activities, while TBAs – considered unskilled health workers – are trusted members of the community who support pregnancy and childbirth. Both HHPs and TBAs are volunteers. Other, smaller cadres operate in South Sudan but they are not mentioned extensively in policy.

Policy guidance for community health providers is often unclear. For instance, the term "CHW" is sometimes used to describe community health providers as a whole rather than the specific CHW cadre, and the roles of MCHWs, CMWs, and TBAs are described in very general terms.

Furthermore, information about their scopes of practice and processes related to selection, training, supervision, data collection, incentives, and coordination is often vague and minimal. In fact, the 2011 *BPHNS* acknowledges the lack of job descriptions for health workers at all levels of the health system

and other implementation challenges, including insufficient and irregular compensation, lack of supervision support, limited information about the number of health providers, and high staff turnover and absenteeism.

The *BPHNS* does, however, provide details about community groups, specifically health committees, that manage community-level health facilities. *Payam* (or sub-county) level health committees manage PHCCs, and health committees in *bomas* (which comprise a group of villages) oversee PHCUs. Health committees may also exist at the village level. These committees include local government leaders as well as members of community interest groups who support health facilities and community health-related activities and serve as a link between communities, the county health department (CHD), and the state ministry of health (SMOH). More information on these health committees is provided in the Leadership and Governance section of this profile. Policies also mention that other civil society organizations support advocacy, implementation efforts, and awareness-raising in communities.

Table 2. Key Health Indicators, South Sudan

Total population[1]	12.7 m
Rural population[1]	81%
Total expenditure on health per capita (current US$)[2]	$30
Total fertility rate[1]	6.7
Unmet need for contraception[3]	29.8%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	2.6%
Maternal mortality ratio[4]	789
Neonatal, infant, and under 5 mortality rates[5]	39 / 60 / 93
Percentage of births delivered by a skilled provider[6]	19.4%
Percentage of children under 5 years moderately or severely stunted[7]	31.1%
HIV prevalence rate[8]	2.5%

[1]PRB 2016; [2]World Bank 2016; [3]United Nations 2015; [4]World Health Organization 2015; [5]UNICEF et al., 2016; [6]Ministry of Health and National Bureau of Statistics, South Sudan 2010; [7]International Food Policy Research Institute 2016; [8]UNAIDS 2015.

Health programming in South Sudan is financially supported by international donors who contract NGOs and implementing partners to deliver programs and interventions, including those at the community level.

In South Sudan, community health services are delivered through vertical programs (e.g., malaria, guinea worm eradication) and integrated programs (e.g., community-based nutrition and food security) from primary health care structures and in communities. One of the aims of the *BPHNS* is to better integrate these programs under one service package to improve coordination and efficiency for implementation.

Health programming is supported through partnerships between the government of South Sudan and three primary donors—the World Bank, USAID, and the UK Department for International Development— which have divided the country into three geographical areas. Within its respective area, each donor uses distinct financing mechanisms and contractual arrangements with nongovernmental organizations (NGOs) and other partners to deliver programs and interventions aligned with *HSDP* objectives. Community health programming, including management of health facilities and community health providers, is largely conducted by government partners.

LEADERSHIP AND GOVERNANCE

Community health service delivery in South Sudan is managed and coordinated across the national, state, county, and community levels. Each has a distinct role in supporting policy and program efforts as described below:

- At the **national level**, the MOH and its sub-sections, known as directorates, are responsible for overall leadership of the health sector, policy formulations, strategic planning, resource mobilization and budgeting, setting standards and quality assurance, working with health development partners, and coordinating operational research and regulation.
- The SMOH is responsible for coordination, supervision of activities, and enforcement of policy and resource allocation for secondary health care at the **state level**.[1]
- At the **county level**, the CHD is responsible for primary health care, which includes preventive services and conducting other community-based health activities. In addition, the CHD provides guidance to health facilities such as PHCUs, PHCCs, and county hospitals. CHD representatives supervise CHWs, CMWs, and MCHWs. The county health management team (CHMT), comprising CHD and selected county hospital staff, focuses on delivering basic health services, assessing referrals from lower level facilities, strategic planning, managing information systems, monitoring activities at PHCCs and PHCUs, and epidemiological surveillance.
- The **community level** comprises three sublevels: the payam, the boma, and the village. At each, health committees support health-related activities. In payams, leaders, administrators, and boma representatives form health committees to facilitate health facility management, including at PHCUs, PHCCs, and county hospitals. At the lower levels, boma health committees (BHCs) and village health committees (VHCs) comprise at least six community leaders, administrators, and members of interest groups including church, youth, women, and education groups. CHWs serve as committee secretaries. These committees plan and implement community health programs, foster community engagement and ownership, develop local leadership, enforce the referral system and disease surveillance, monitor and evaluate health activities and use of resources, and participate in emergency preparedness activities with the CHD and SMOH. BHCs and VHCs also provide administrative supervision to the various community health providers—particularly HHPs and TBAs—in addition to the technical input that these cadres receive from CHWs, MCHWs, and CMWs at health facilities. BHC, VHC, and PHCU staff report to the CHD.

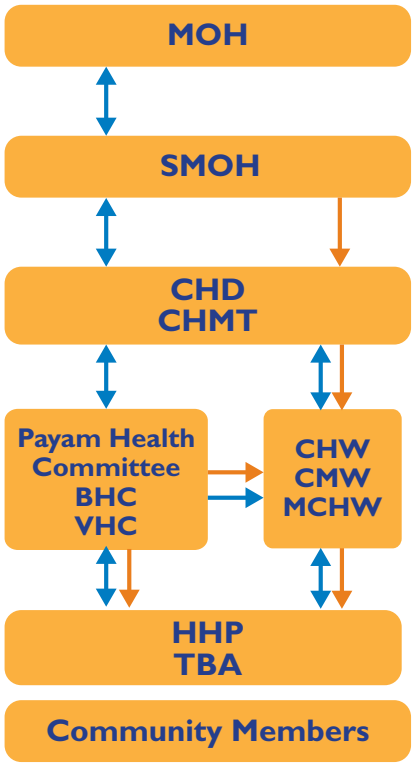
Health committees work with communities to manage health facilities, support program implementation, and provide oversight to community health providers.

Figure 1 summarizes South Sudan's health structure, including managing administrative bodies, service delivery points, and key actors and their relationships at each level.

1 Theoretically, the SMOH report to the MOH, but the *HSDP* indicates that responsibilities of the MOH and SMOH are unclear, that SMOH are not always held accountable to the MOH, and that there is often poor coordination between the MOH, SMOH, and NGOs that implement community programming, making health service delivery challenging.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOH and its directorates	Regional Teaching Hospital	
State	SMOH	State Referral Hospital	
County	CHD CHMT	County Hospital	
Community: Payam	Payam Health Committee	PHCC	
Community: Boma	BHC	PHCU	
Community: Village	VHC	CHW HPP TBA	



* International NGOs and donors support community health programming and structures at all levels.

Supervision →
Flow of community-level data →

HUMAN RESOURCES FOR HEALTH

The five main cadres of service providers at the community level have different roles. CHWs, CMWs, and MCHWs are more skilled and are often supported by NGOs. They are paid workers and provide a range of services from the PHCU or PHCC.

- CHWs perform basic primary health care service provision, including distribution of FP, integrated case management of childhood illness, nutrition screening, and selected antenatal and postnatal care interventions. Ideally, there are two CHWs per health facility; one manages facility-based services, and the other oversees community-based activities and outreach in the facility's catchment area, often in conjunction with other community health providers like HHPs.
- CMWs are expected to work with CHWs to deliver basic preventive and curative services and conduct deliveries, though available policy does not elaborate on the specific services they provide. The MOH anticipates scaling up CMWs with consideration to retrain them as professional midwives.

- The MCHW scope of work is also not very clear. Policy indicates that they focus on providing basic maternal and child health services from PHCUs. One policy indirectly suggests some may conduct deliveries, though they are not considered skilled or professional midwives.

CHWs, CMWs, and MCHWs link the county and community levels. Policies sometimes refer to these three cadres interchangeably, as their roles are not well-defined and may vary based on the NGO or government partner that supports the health facility from which they work.

HHPs and TBAs are volunteers who work in communities. HHPs provide a range of educational, preventive, and curative health services based on the needs of the communities that they serve. As such, there is no set scope of work for the cadre, but rather general guidance about the services they might provide.

TBAs administer simple reproductive health care interventions and are often supported by NGOs. While the MOH acknowledges that they are trusted figures who perform deliveries in remote areas that might not have alternatives for pregnant women, it intends to phase them out and to replace them with trained CMWs or professional midwives. Because of their influence in communities, policies suggest retraining TBAs as formal community health providers, like HHPs and CHWs, in the future.

HHPs and TBAs report to the BHC or VHC and receive technical support from health facility staff, such as CHWs, CMWs, and MCHWs.

Table 3 provides an overview of these community health providers.

Table 3. Community Health Provider Overview

	CHWs	CMWs	HHPs	MCHWs	TBAs
Number in country	At least 1,894 CHWs and MCHWs combined[1]	96[1]	*Information not available in policy*	At least 1,894 CHWs and MCHWs combined[1]	*Information not available in policy*
Target number	1,600-2,152[2]	408-568[2]	*Information not available in policy*	1,218-1,584[2]	*Information not available in policy*[3]
Coverage ratios and areas	2 CHWs : 1 community-level health facility[4] Operate in urban, rural, and peri-urban areas Residents of the area they serve	1-2 CMWs : 1 community-level health facility[4] Operate in urban, rural, and peri-urban areas Residents of the area they serve	1 HHP: 20-50 households (approximately 134-335 people), although other guidance suggests that communities determine the number of households HHPs should serve. Operate in urban, rural, and peri-urban areas	2 MCHWs : 1 PHCU Operate in urban, rural, and peri-urban areas	Approximately 1 TBA : 1 village Varies since TBAs are not a formal community health provider cadre
Health system linkage	Employed by the government or an NGO supporting government programs; provide services at PHCUs and PHCCs.	Employed by the government or an NGO supporting government programs; provide services at PHCUs and PHCCs.	Receive training and support from government systems and NGOs; provide services for government programs at the boma and village levels and operate in conjunction with staff at PHCUs and PHCCs.	Employed by the government or an NGO supporting government programs; provide services at PHCUs.	Unclear, but they are sometimes supported by NGOs who work to implement government-led community programming.
Supervision	Supervised by CHD representatives. The BHC or VHC provides some general oversight of the health facility and its staff, including CHWs.	Supervised by CHD representatives. The BHC or VHC provides some general oversight of the health facility and its staff, including CMWs.	Supervised by the BHC/VHC, with technical support from PHCU and/or PHCC staff. The specific technical supervisor is not indicated, but s/he should be responsible for supervising about 20 HHPs.	Supervised by CHD representatives. The BHC or VHC provides some general oversight of the health facility and its staff, including MCHWs.	Supervised by the BHC/VHC, with technical support from PHCU and/or PHCC staff.
Accessing clients	On foot Bicycle Clients travel to them	Bicycle Clients travel to them	On foot Clients travel to them	Bicycle Clients travel to them	*Information not available in policy*

Table 3. Community Health Provider Overview

	CHWs	CMWs	HHPs	MCHWs	TBAs
Selection criteria	Male or female[5] Residents of the area they serve	Residents of the area they serve	Willing to work as a volunteer Available night and day Honest and hardworking Trusted by the community Member of the community and speaks the language Willing to learn Willing to speak in public Literacy ideal but not required Basic or primary education	Male or female[5] Residents of the area they serve	*Information not available in policy*
Selection process	*Information not available in policy*	*Information not available in policy*	HHPs are identified and recruited by the village leaders and/or the BHC/VHC. Selection occurs during a community meeting at which at least half of the village should be represented. Final selected candidates are vetted by the CHD and village leaders to ensure they are respected. Additional requirements include ensuring gender balance among selected HHPs, HHP representation in all villages, and selecting candidates who are most likely to remain in their role.	*Information not available in policy*	*Information not available in policy*

Table 3. Community Health Provider Overview

	CHWs	CMWs	HHPs	MCHWs	TBAs
Training	*Information not available in policy*[6]	*Information not available in policy*[6]	Ideally, HHPs are trained by the implementing NGO using a nationally approved curriculum over the course of 9 months. However, policy recognizes this may not be feasible, and that it may make more sense to just train HHPs on the tasks they need to meet the specific needs identified by the communities they serve. HHP training can thus be tailored to meet those needs. Training should be in stages; HHPs should receive semi-annual periodic refresher trainings.	*Information not available in policy*[6]	TBAs receive training in safe delivery methods by NGOs. The *BPHNS* indicates that there is no intention to further train TBAs; instead, they want to focus attention on skilled birth attendants like CMWs. In the meantime, TBAs may provide basic reproductive health interventions.
Curriculum	*Information not available in policy*[6]	*Information not available in policy*[6]	*Home Health Promoters Curriculum Outline* (2011). Includes 6 units: HHP general information; community case management; maternal/newborn/child health; behavior change communication; WASH; commodity management and distribution.	*Information not available in policy*[6]	*Information not available in policy*[6]
Incentives and remuneration	Paid workers, but details are not available in policy. Other incentives are likely at the discretion of the NGO or other implementing partner and communities.	Paid workers, but details are not available in policy. Other incentives are likely at the discretion of the NGO or other implementing partner and communities.	Policy indicates that HHPs are volunteers and do not receive incentives. However, policy encourages communities to support and accommodate HHPs as possible, including recognition at community celebrations and non-monetary incentives. It also points to the possibility of career advancement for HHPs, such as eventually becoming CHWs.	Paid workers, but details are not available in policy. Other incentives are likely at the discretion of the NGO or other implementing partner and communities.	*Information not available in policy*[6]

[1] According to South Sudan's *National Reproductive Health Policy (2013)*, as of 2011, there were a total of 1,894 CHWs and MCHWs (combined) and 96 CMWs trained in reproductive health. However, separate NGO documentation indicates over 4,000 CHWs in 2011, though it does not specify how this cadre was defined.
[2] Rough calculation based on a) approximately 609–792 PHCUs and 204-284 PHCCs in the country, given varying estimates; and b) an ideal number of approximately 2 CHWs per health facility (PHCU and PHCC), an ideal number of 2 MCHWs per PHCU, and an ideal number of 1 CMW per PHCU or 2 CMWs per PHCC. There is contradictory information in the BPHNS about this.
[3] Policy indicates that the MOHS is trying to phase out TBAs, instead training them as professional midwives to conduct deliveries. It may also recruit them for other roles, such as CHWs and HHPs.
[4] Refers to either a PHCU, which covers approximately 15,000 people, or a PHCC, which covers approximately 50,000 people.
[5] In practice, CHWs are male or female whereas MCHWs tend to be predominantly female.
[6] It is likely at the discretion of the NGO or implementing partner to determine this.

HEALTH INFORMATION SYSTEMS

The *HSDP* acknowledges that South Sudan's routine health management information system is not fully operational. It indicates that in practice, information is obtained in various manners and from a variety of sources – including assessments, mapping exercises, and surveys – and that data from vertical programs often travels directly from facilities to the MOH instead of by way of the state and county levels. Further, there are no standardized reporting forms for tracking data between health facilities, NGOs, and vertical programs, and there is limited capacity for data analysis.

However, policies provide a rough outline of how community-level data should flow. Community health providers are expected to use pre-designed forms and register books to collect and report data at the first level of the health management information system. For instance, HHPs are supposed to use forms to track their case management data, health promotion activities, and commodity management. Boma and village leaders[2] then review this information before it is transmitted to the PHCU through weekly and monthly reports. From there, data is transferred to the PHCC at regular intervals and then to the CHD. At the CHD, data should be aggregated, entered into a district/county health information system, and submitted electronically to the SMOH, which should send it on to the MOH. Policies indicate a bidirectional flow of information, with feedback provided at each level. The blue arrows in Figure 1 depict the intended flow of information that South Sudan's policies describe.

HEALTH SUPPLY MANAGEMENT

Policies are not specific about how community health providers should acquire the supplies they need, though they suggest that ideally one health supply chain runs from the central level to the state, county, and health facility levels, where community health providers can access kits that contain the supplies they need. Policies also point to the important role of NGOs in the procurement and distribution of

Table 4. Selected Medicines and Products Included in the *Southern Sudan Essential Medicine List* (2007)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☐	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☐	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☐	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

2 Policies do not specify if these leaders are members of the BHC/VHC.

supplies, particularly when there are stockouts. To mitigate potential supply disruption, stakeholders such as NGOs, civil society organizations, and donors have established technical working groups to oversee key technical areas, including pharmaceuticals, medical supplies, and equipment.

Available policy does not describe where or how community health providers may dispose of medical waste.

The full list of commodities that CHWs, MCHWs, CMWs, HHPs, and TBAs provide is not available but information about selected medicines and products included in the *Southern Sudan Essential Medicine List* (2007) is provided in Table 4.

SERVICE DELIVERY

The 2011 *BPHNS* outlines the basic primary and health care services in the country. Within the document, specific service packages include a minimum initial service package for reproductive health, a community-based child survival package, and a basic package of health and nutrition services for schools.

In South Sudan, service delivery is organized by the type of services needed, and providers are guided by policy, training, and experience. Clinical services are generally delivered at the PHCU, and antenatal care, FP, and immunizations are also offered through scheduled outreach services. Mass measles and polio campaigns and guinea worm eradication programs are conducted door-to-door to ensure maximum reach. HHPs go to households to deliver preventive health commodities, such as condoms, or simple medicines like oral rehydration salts and zinc for children.

Health education may be provided at public gatherings; for instance, HPPs may hold regular meetings to educate the community on disease prevention. CHWs organize health education sessions daily at the PHCU or PHCC. Community mobilization may be conducted door-to-door, at the facility, at churches, or at community or group meetings. This information is summarized in Table 5.

Community health providers refer clients to the PHCU or the nearest PHCC. TBAs and HHPs refer to health facility-based staff, including CHWs, CMWs, and MCHWs, for services they cannot provide. Available policies do not mention guidance for counter referrals.

Using FP as an example, community health providers may provide condoms, oral contraceptive pills, as well as guidance on the lactational amenorrhea method and fertility awareness methods.[3] Additionally, they may refer clients to:

- **PHCUs** for the same methods provided by community health providers, as well as injectable contraceptives, and emergency contraceptives.
- **PHCCs** for the same methods available at PHCUs as well as implants and intrauterine devices (IUDs).

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Health posts or other facilities
	Special campaigns
Health education	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Provided door-to-door
	Health posts or other facilities
	Community meetings
	Mothers' or other ongoing groups

3 The *BPHNS* and the FP-related policies provide contradictory information on whether or not CHWs may provide emergency contraceptive pills and injectable contraceptives. It is likely they may provide them from health facilities but not in communities.

- **County hospitals** for the same methods available at PHCCs as well as permanent methods.

Table 6 details selected interventions delivered by CHWs, CMWs, MCHWs, HHPs, and TBAs in the following areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

Please note that there is limited guidance about the specific interventions that South Sudan's community health providers can provide. Much of this information is inferred from a variety of documents rather than specific job descriptions and curricula.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral[1]	Follow-up
FP	Condoms[2]	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	CycleBeads®	CHW[5]	Unspecified	Unspecified	CHW[4]
	Emergency contraceptive pills[2]	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	Implants	CHW, CMW, HHP, MCHW, TBA	No	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	Injectable contraceptives[2]	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	IUDs	CHW, CMW, HHP, MCHW, TBA	No	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	Lactational amenorrhea method	CHW, CMW, HHP, MCHW, TBA		HHP	CHW[4]
	Oral contraceptive pills[2]	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	Other fertility awareness methods	CHW, CMW, HHP, MCHW, TBA		HHP[2]	CHW[4]
	Permanent methods	CHW, CMW, HHP, MCHW, TBA	No	CHW, CMW, HHP, MCHW, TBA[3]	CHW[4]
	Standard Days Method	CHW, CMW, HHP, MCHW, TBA		HHP[2]	CHW[4]
Maternal health[6]	Birth preparedness plan	HHP		Unspecified	Unspecified
	Iron/folate for pregnant women	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
	Nutrition/dietary practices during pregnancy	CHW, HHP		CHW, HHP	Unspecified
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	MCHW[7]	CHW, HHP	Unspecified
	Recognition of danger signs during pregnancy	HHP	HHP	HHP	Unspecified
	Recognition of danger signs in mothers during postnatal period	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Newborn care[6]	Care seeking based on signs of illness	CHW, HHP			Unspecified
	Chlorhexidine use	Unspecified	Unspecified	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	HHP		Unspecified	Unspecified
	Nutrition/dietary practices during lactation	HHP		Unspecified	Unspecified
	Postnatal care	CHW, HHP	No	CHW, HHP	Unspecified
	Recognition of danger signs in newborns	HHP	HHP	HHP	Unspecified
Child health and nutrition[6]	Community integrated management of childhood illness	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
	Exclusive breastfeeding for first 6 months	CHW, HHP		CHW, HHP	Unspecified
	Immunization of children[8]	CHW, HHP	No	CHW, HHP	Unspecified
	Vitamin A supplementation for children 6–59 months	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
HIV and TB[6]	Community treatment adherence support, including directly observed therapy	Unspecified	Unspecified	CHW, HHP	CHW, HHP
	Contact tracing of people suspected of being exposed to TB	Unspecified	HHP	Unspecified	Unspecified
	HIV testing	CHW, HHP	No	CHW, HHP	Unspecified
	HIV treatment support	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
Malaria[6]	Artemisinin combination therapy[9]	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
	Long-lasting insecticide-treated nets	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified
	Rapid diagnostic testing for malaria	Unspecified	Unspecified	CHW, HHP[10]	Unspecified

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
WASH[6]	Community-led total sanitation	CHW, HHP	CHW, HHP		
	Hand washing with soap	CHW, HHP			
	Household point-of-use water treatment	CHW, HHP			
	Oral rehydration salts	CHW, HHP	CHW, HHP	CHW, HHP	Unspecified

[1] Policies do not necessarily specify if the cadres listed in the referral column may refer for these services. Rather, these interventions are available at the PHCC, PHCU, and county hospital levels, and thus referrals must be made by health workers working in lower tiers.
[2] Available policies do not explicitly state that each cadre can provide this FP method; rather, this is an inference based on information gleaned across all policies. In reality, the FP methods that the cadres may provide depend on their training, which is largely determined by NGOs, and will therefore vary.
[3] Available policies indicate that community health providers should refer for FP methods beyond their capacity. It does not provide referral information specifically for each cadre except HHPs.
[4] Follow-up for FP is listed only briefly in the *Family Planning Training for Health Facility Staff in South Sudan* and is not specific to method. This manual only specifically calls out CHWs, though in reality it may apply to the other cadres.
[5] CycleBeads are only listed only briefly in the *Family Planning Training for Health Facility Staff in South Sudan*. This manual only specifically calls out CHWs, though in reality it may apply to the other cadres.
[6] Policies generally indicate that TBAs, CMWs, and MCHWs are allowed to administer simple maternal and child health and nutrition interventions, but apart from FP distribution, the services are not specified; there is greater detail about the services the CHW and HHP cadres may administer. It is likely that CMWs and MCHWs may be allowed to deliver many of the same services as CHWs.
[7] The policy on prevention of postpartum hemorrhage mentions MCHWs but none of the other types of community health providers. It is the only policy that indicates that MCHWs can assist deliveries.
[8] Also applies to newborns.
[9] For children under five years as part of integrated community case management.
[10] Community health providers may refer patients to PHCUs and PHCCs for "clinical" diagnosis of malaria, which policy differentiates from "laboratory" diagnosis, which is only at a PHCC or higher level facility. Rapid diagnostic testing is not specifically mentioned in available policies.

KEY POLICIES AND STRATEGIES

Ministry of Health, Directorate General of Planning and Coordination, Republic of South Sudan. 2011. *Health Management Information System Participant Manual.* Juba: Republic of South Sudan.

Ministry of Health, Government of Southern Sudan. n.d. *Maternal, Neonatal and Reproductive Health Strategy (2009 – 2015)* (Draft).

———.2007. *Southern Sudan Essential Medicines List.* Available at http://apps.who.int/medicinedocs/documents/s19450en/s19450en.pdf (accessed September 2016).

Ministry of Health, Republic of South Sudan. 2011a. *Approach to Working with Health Committees (Draft)*. Juba: Republic of South Sudan.

———. 2011b. *Home Health Promoters Implementation Guide*. Juba: Republic of South Sudan.

———. 2011c. *Home Health Promoter Curriculum Outline*. Juba: Republic of South Sudan.

———. 2011d. *The Basic Package of Health and Nutrition Services in Primary Health Care*. Juba: Republic of South Sudan.

———. 2012a. *Clinical Guidelines for the Prevention and Management of Postpartum Haemorrhage in South Sudan (Draft)*. Juba: Republic of South Sudan.

———. 2012b. *Health Sector Development Plan (2012-2016)*. Juba: Republic of South Sudan. Available at https://extranet.who.int/nutrition/gina/sites/default/files/SSD%202012%20HEALTH%20SECTOR%20DEVELOPMENT%20PLAN%202012-2016.pdf (accessed September 2016).

———. 2013a. *Family Planning Policy*. Juba: Republic of South Sudan. Available at http://pdf.usaid.gov/pdf_docs/PA00JVB1.pdf (accessed September 2016).

———. 2013b. *Family Planning Training for Health Facility Staff in South Sudan: Trainer's Handbook*. Juba: Republic of South Sudan.

———. 2013c. *National Reproductive Health Policy*. Juba: Republic of South Sudan. Available at https://goo.gl/C6p6YS (accessed September 2016).

———. 2013d. *National Reproductive Health Strategic Plan (2013-2016)*. Juba: Republic of South Sudan. Available at http://pdf.usaid.gov/pdf_docs/PA00JVB3.pdf (accessed September 2016).

———. 2013e. *Policy Framework (2013-2016)*. Juba: Republic of South Sudan. Available at https://www.mindbank.info/item/6284 (accessed September 2016).

South Sudan HIV/AIDS Commission. 2015. *South Sudan National HIV Policy (Draft)*. Juba: Republic of South Sudan.

REFERENCES

Care International. n.d. *Critical Diagnosis: The Case for Placing South Sudan's Healthcare System at the Heart of the Humanitarian Response*. Available at https://www.care.at/wp-content/uploads/2015/10/02_CRITICALDIAGNOSIS.pdf (accessed October 2016).

International Food Policy Research Institute. 2016. *Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030*. Washington, DC: International Food Policy Research Institute. Available at http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/130354/filename/130565.pdf (accessed September 2016).

Ministry of Health and National Bureau of Statistics, South Sudan. 2010. *South Sudan Household Survey 2010, Final Report*. Juba, South Sudan. Available at http://static1.1.sqspcdn.com/static/f/750842/25554023/1413444076180/SS+HHS+2010+Final+2010+Report.pdf?token=YkhogtKPjsGXxEZXde0P2xmxOTE%3D (accessed September 2016).

PRB. 2016. *2016 World Population Data Sheet*. Washington, DC: PRB. Available at http://www.prb.org/pdf16/prb-wpds2016-web-2016.pdf (accessed September 2016).

UNAIDS. 2015. "Aids Info." Available at http://aidsinfo.unaids.org/ (accessed June 2016).

UNICEF, World Health Organization, United Nations Population Divison, and World Bank Group. 2016. "Child Mortality Estimates." Available at http://www.childmortality.org/index.php?r=site/graph#ID=SSD_South%20Sudan (accessed September 2016).

United Nations, Department of Economic and Social Affairs, Population Division. 2015. *Trends in Contraceptive Use Worldwide 2015*. New York: United Nations. Available at http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf (accessed September 2016).

World Bank. "The World Bank DataBank: Health expenditure per capita (current US$)." Available at http://beta.data.worldbank.org/indicator/SH.XPD.PCAP?view=chart (accessed June 2016).

World Health Organization. 2015. *Trends in Maternal Mortality 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva: World Health Organization. Available at http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf (accessed July 2016).

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