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Walden University

College of Health Sciences

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Gillian Garnett

has been found to be complete and satisfactory in all respects,
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Walden University
2018

Abstract

Women's Experiences Using Health Facilities for Childbirth in South Sudan

by

Gillian Garnett

MPH, University of Nottingham, 2006

BSc, University of Guyana, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

November 2018

Abstract

There is low use of health facilities for childbirth in South Sudan despite the majority of households reporting access to a health facility. South Sudan has a high maternal mortality ratio with 789 maternal deaths for every 100,000 live births. The absence of a midwife during labor and delays in reaching health facilities for childbirth remain the leading contributing factors to the high maternal mortality. Little is known, however, about factors influencing use and non-use of health facilities for delivery in the country. This phenomenological study, therefore, seeks to build a body of evidence by describing the experiences of women using health facilities for childbirth. Applying the health belief model, structured interviews were conducted confidentially with 20 women between the ages of 18 and 45 who delivered at the Juba Teaching Hospital. Interviews were voice recorded, transcribed, and analyzed by hand-coding and through NVivo computer software. A review of copied data, comparison with field notes, and member checking were done to ensure data quality. Five broad themes emerged based on the research questions and linked these to the theoretical model. Findings revealed that women received support and assistance during their childbirth experience at the hospital from their husbands, mothers-in-law, health workers, and neighbors. Women reported negative factors such as hunger and positive factors such as care provided by midwives as affecting their childbirth experiences. This research could contribute to improving health outcomes for women and newborns. This study has implications for positive social change by transforming the provision of maternity services in South Sudan.

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Dedication

I dedicate this research to the many women who have never made it to a health facility or have died from complications of pregnancy and childbirth globally. I would also like to dedicate this dissertation to the loving memory of my mother who passed away while I was completing my research. Even though she is not with me physically, I know that she would have been proud of the progress that I have made and I can feel her smiling down from above. She has always believed in education and provided me with love, guidance, and support throughout my academic life. I also dedicate this research to my family members, dad, sisters, brother, husband, and son. They have provided support, advice, and prayers throughout my studies and work. I am grateful to all of them. I am also thankful to the many colleagues at work, friends, and supporters who have challenged me to take on this arduous and long journey. I dedicate this research to you all for your love, support, kindness, and prayers. I wish you all God's most abundant blessings.

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I would like to say thank you to the almighty God for his mercies and blessings and for giving me the strength to make it through this journey. Without him, it would not have been possible. I would also like to thank my dear husband and son who provided me first with space and time to do this. I would also like to thank them for their patience, support, and assistance at all times. I would like to thank my sisters, brother, dad, friends, and co-workers for all their help and prayers. I would also like to thank my supervisor and chair, Dr. Patrick Tschida. He is a real mentor and supervisor. Thank you for the guidance, help, assistance, and advice throughout my journey. Thank you to my committee member, Dr. Suzanne Richins for your kind inputs and information throughout this journey. To the editors, librarians, academic advisers and all of the faculty staff of Walden University who made my experience such a rewarding one, I say thank you. I have been truly blessed to have all of this support.

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Chapter 1: Introduction to the Study

Introduction

Pregnant women and girls in South Sudan risk dying from complications of pregnancy and childbirth because many of them stay at home to give birth alone (Ministry of Health [MoH], Republic of South Sudan, 2013). The last demographic health survey conducted in South Sudan revealed that there is low use of health facilities for childbirth (MoH, & South Sudan National Bureau of Statistics [NBS], 2011). The absence of a skilled birth attendant such as a midwife during delivery, and delays in getting to health facilities for childbirth, remain among the leading contributing factors for the high number of maternal and newborn deaths around the world (Every Woman Every Child, 2015). South Sudan has a high maternal mortality ratio with the United Nations (UN) estimates showing that there are 789 maternal deaths for every 100,000 live births in the country (World Health Organization [WHO], 2015). Initiatives to improve maternal health outcomes are, therefore, critical for development and nation-building in the world's newest country (Kolok, 2013; MoH, 2017).

For national development, information is needed on the maternal health situation so that evidence-based solutions could be implemented to address challenges (Every Woman Every Child, 2015; WHO, 2017). The South Sudan Government has identified reducing maternal mortality and increasing uptake of institutional deliveries as national priorities (MoH, 2017; MoH, 2014). Little is known, however, about factors influencing the use and non-use of maternity services in the country because of limited research and data (Independent Evaluation of the MDTF-SS, 2013; Kolok, 2013). There are many

challenges in data collection and insufficient evidence available in the country on the maternal health situation (MoH, 2017; Johnson, Ockelford, & Power, 2013). I, therefore, designed this study to contribute to the body of evidence on maternal health care in South Sudan to contribute to the development of programs to improve maternal health.

Overview of Dissertation

I built this study on current knowledge with regards to maternal health. In this dissertation, I will provide the results and findings from the dissertation research on this issue. Chapter 1 includes an introduction to the study, providing the background, and an overview. The next chapter includes the context of the survey regarding previous literature, identifying gaps, and the theoretical framework used for the overall approach and direction of the study. Chapter 3 includes an overview of the methodology for this study, which was qualitative, including information on the participants, the process for data collection, and analysis. Chapter 4 includes the findings and results of the research, while Chapter 5 includes the conclusion, potential for social change, the implications of the study, and recommendations for practice and further research.

Background

South Sudan became independent in July 2011, after many years of internal conflict and civil war (Government of Southern Sudan [GOSS], 2011). This opportunity for growth and development as a new nation, however, was severely challenged as a result of the unfortunate maternal health situation in the country (Johnson et al., 2013; Kolok, 2013). The high number of maternal deaths as a result of pregnancy and delivery complications continued to threaten nation building (Kolok, 2013). Pregnant women

accessing childbirth services at health facilities is considered one strategy for improving maternal health and midwifery care in this nascent country (MoH, 2017; WHO, 2016).

There is evidence that with quality midwifery services, deaths of mothers and newborn babies during pregnancy and childbirth are significantly reduced (UNFPA, WHO, International Confederation of Midwives [ICM], 2014). Utilization of health facilities for delivery in South Sudan is low with 11.5% of pregnant women giving birth in a health facility, and only 19% of women receiving skilled assistance at birth (MoH, & NBS, 2011). This low uptake continues to take place, although, 40% of pregnant women reported attending at least one antenatal clinic visit, and 70% of the population has access to a health facility (MoH, & NBS, 2011; NBS, 2013). With the high number of illiterate traditional birth attendants and a few qualified midwives, the non-use of health facilities for childbirth, therefore, increases the risk of women dying when faced with complications of pregnancy and childbirth (Johnson et al., 2013; Kolok, 2013).

Need and Importance of this Research

There have been several studies conducted globally on the use of health facilities. Many of these studies included factors influencing and inhibiting use of facilities for childbirth (Chukwuma et al., 2017; Enuameh et al., 2016; Kawakatsu et al., 2014; Loke, Davies, & Li, 2015; Speizer, Story, & Singh, 2014). Researchers found, however, that there has not been adequate empirical research in South Sudan on this issue because of the weak health management information system (MoH, 2017). The country implemented the last essential national health survey in 2010, over 7 years ago. Further, not much has been included on quality of care issues in general and specifically with regards to services

provided to women during childbirth (Freedman, & Kruk, 2014). Several evaluations and assessment reports were done using already existing data from the Household Survey (Independent Evaluation of the MDTF-SS, 2013; Mugo, Dibley, & Agho, 2015). There has been no original research directly among participants focused on their experiences using health facilities in the country.

In this study, I constructed a body of evidence on the experiences shared by women on the situations and context contributing to and affecting their decisions, and use of health facilities for childbirth. Findings could influence the provision of maternity services in the country and provide information to help understand the low use of health facilities for birth. This research could further help policymakers develop programs and policies that could positively impact on public confidence and use of maternity services.

Problem Statement

Pregnancy and childbirth-related complications can occur at any time, so giving birth outside a health facility alone at home without skilled attendance could have severe consequences for pregnant women and their babies (Every Woman Every Child, 2015; WHO, 2016). Lack of access to maternal health care at facilities and skilled attendance at birth are significant contributory factors for the high number of maternal deaths and disabilities globally (Every Woman Every Child, 2015; Say et al., 2014; WHO, 2016). A midwife could provide as much as 87% of essential maternal and child health services needed (UNFPA et al., 2014). In South Sudan, there are many unskilled and illiterate traditional birth attendants in the community, with the few qualified midwives based at health facilities (Independent Evaluation of the MDTF-SS, 2013). Strategies that will

increase the uptake of health facilities for childbirth, therefore, remain a quick option for reversing the maternal health situation in the country (MoH, 2014; MoH, 2017). The absence of information is also hindering the development of appropriate programs and policies (MoH, 2017).

With little data available in South Sudan on the use of maternity services, some researchers suggest that there are several contextual and community factors contributing to the limited use of health facilities for childbirth (Green, 2014; MoH, 2017; UNOCHA, 2016). These factors are mainly explorative and not grounded in original research (MoH, 2017). There is evidence, however, that strategies for improving maternal health must address the underlying cause of limited use of health facilities and low uptake of institutional deliveries (Every Woman Every Child, 2015; WHO, 2016). This research could, therefore, contribute to this body of knowledge on the use of health facilities for childbirth, confirming or disproving previous studies

Purpose of the Study

I applied the health belief model (HBM) to this study to understand the lived experiences of women giving birth in health facilities. The purpose of this study was to describe the experiences of women deciding to go and to use a health facility (hospitals or health center) for childbirth. I used the phenomenological approach as the research design which best fits an investigation of this phenomenon.

Central Phenomenon

The phenomenon that I focused on in this study was the experience of women deciding and giving birth in a health facility such as a health center or hospital. The

phenomenological approach speaks to the lived experiences of a group of people on a particular phenomenon (Creswell, 2014; Creswell & Poth, 2018).

Research Questions

The central research question for this study was: What are the experiences of women using a health facility (hospital or health center) for childbirth in South Sudan? The following subquestions aided me in answering the central question:

- What are the context(s) and situations that influence women to decide and use a health facility for childbirth?
- What are the context(s) and situation(s) that prevented women from deciding and using a health facility for childbirth?
- How have women described their experiences of childbirth in health facilities in South Sudan? What are some of the reasons women give for their descriptions of the experiences?

Theoretical or Conceptual Framework

Researchers used many health educational and behavioral theories to explain and understand decision-making and action (Edberg, 2015; Hayden, 2017). Some studies analyzed the health belief model (HBM) in decision- making (D’Angelo, 2016). Few researchers, however, applied this model to explain and understand individual experiences related to using services particularly for childbirth (Mohtasham, & Atefeh, 2013; Loke, Davies, & Li, 2015). I, therefore, applied the HBM as the theoretical framework to better understand the use of childbirth services in South Sudan.

Applying the Health Belief Model

Three psychologists developed the HBM in the United States in 1952: Godfrey Hochbaum, Stephen Kegels, and Irwin Rosenstock (Jans, & Becker, 1984; Rosenstock, 1974). I applied the six constructs of HBM influencing decision making and action in this research. The classical theorist, Rosenstock (1974) identified these elements as:

- the perceptions of susceptibility;
- the severity of consequences;
- the benefits and barriers to taking action;
- the cues and prompts for action;
- an individual's beliefs and capacity to take action;

Once applied in my research, these constructs could help to explain further the experiences of women acting to deliver in health facilities, in particular highlighting those factors that influenced or affected their experiences giving birth.

In this research, I used the HBM to explain the data and information gathered on the experiences of women giving birth in health facilities. I used the theory before to analyze the observations made in this research. Researchers have found that a theoretical construct can be used before data collection to help in the development of research questions, and then used again for analysis and interpretation of the data (Creswell, 2014; Glanz, Rimer, & Viswanath, 2015; Hayden, 2017). The application of theory before data collection and analysis could also help to identify gaps and the usefulness of theoretical models for health research (Hayden, 2017).

Nature of the Study

I conducted a qualitative study using phenomenology to describe experiences of women using health facilities for childbirth. Phenomenological research provides abundant information to understand complex issues. It allows researchers to focus on the meanings shared by participants and set aside their feelings and perspectives of the problem, referred to as 'bracketing' in qualitative research (Creswell, 2014; Creswell & Poth, 2018; Edberg, 2015). Bracketing allows new and fresh perspectives to come forth on respondents' experiences.

I used several data collection strategies to gather information for the study. The interview is the primary data collection method in phenomenology (Creswell, 2014), so this was the data collection strategy for my research. Creswell & Poth (2018) suggested that other materials used by respondents to explain a phenomenon could be useful in qualitative research. I, therefore, planned to use any other available materials from respondents such as journal entries, drawings, and other audio or visual documents. I selected participants who had experienced the phenomenon of having a childbirth experience in a hospital by purposeful sampling. I completed the data analysis using both manual hand coding and NVivo. Researchers suggested using multiple strategies for data triangulation (Creswell, 2014; Creswell, 2016). I, therefore, used a peer checking the information, NVivo computer software, and hand coding for triangulation of the data. These strategies helped to ensure that I was credible and trustworthy as a researcher, by considering all ethical standards.

Assumptions

One of the premises for this research was that participants would freely provide rich and in-depth descriptions of their experiences using health facilities. As such, participants were expected to be truthful and open in their responses, providing detailed information that will help in understanding this issue. The assumption was that this phenomenological approach is most appropriate in answering the questions and bringing new perspectives on this issue. Additionally, researchers are the principal instruments in qualitative studies and are expected to make known early their personal biases and perspectives which can influence the research (Creswell, 2014; Creswell, 2016; Creswell & Poth, 2018; Marshall & Rossman, 2016). As the researcher, therefore, I set aside and made known early in the study all personal feelings, perspectives, and biases regarding this phenomenon. I did this to allow the real views of participants to come forth.

Definitions of Key Terms Used in this Research

The following are definitions of key terms used in this research:

Childbirth is the process entailed in the delivery of a baby through ordinary means (Every Woman Every Child, 2015; UNFPA et al., 2014; WHO, 2016).

Health facility is a private or publicly managed hospital, Primary Health Care Center, or a Primary Health Care Unit providing health care services to clients (MoH, 2013). In South Sudan, there are only hospitals, health centers, and healthcare units providing health care including childbirth services.

Maternal death is the death of a woman who is pregnant or within 42 days of termination of the pregnancy, regardless of the duration of the pregnancy. Maternal

mortality could be as a result of any cause related to or made worse by the pregnancy or the management of this pregnancy (Say et al., 2014; WHO et al., 2015).

Maternal health is the health of women during pre-pregnancy, pregnancy, labor, and delivery, and after childbirth (UNFPA et al., 2014).

Midwifery is the care provided to women during pregnancy, childbirth, and post-delivery period as well as the care provided to the newborn baby (UNFPA et al., 2014).

Phenomenology is the approach used to describe the experiences of several individuals related to a particular issue or phenomenon (Creswell, 2014)

Skilled assistance at delivery is the assistance provided by a doctor, nurse, or midwife trained and educated to proficiency in healthy pregnancy and childbirth as well as management and referrals of complications (Say et al., 2014; WHO, 2016).

Scope and Delimitations

The study only involved women who had given birth in a health facility without any limitations on the outcome of their delivery. I embraced the lived experiences of women giving birth in a health facility in South Sudan. All respondents experienced the phenomenon of giving birth in a hospital and were, therefore, included in the study.

South Sudan has over 40 different ethnic tribes, experiencing various cultural practices (GOSS, 2011; Green, 2014). Participants were, therefore, drawn from several ethnic tribes in several regions of the country. These tribes include Dinka, Nuer, Bari, Latuka, and Xande Tribes (GOSS, 2011). I also added women from other ethnic tribes who delivered in the hospital in the sample for this research.

Limitations

This study had several limitations. I conducted this research in Juba, the capital city of South Sudan. It was not possible, therefore, to generalize the results from this research to other cities or states given that South Sudan is a vast country, with changing context and situations in each state (MoH, 2017). The research will, however, contribute to the body of evidence on the use of maternal health services in the country. The sample used for this research is small, involving some tribes from Dinka, Nuer, Bari, and Madi ethnic tribes of South Sudan. These tribes, however, have their distinct sociocultural practices that may influence their utilization of maternal health services (Johnson et al., 2013). I cannot, therefore, apply these findings to all other tribes in the country.

As the qualitative researcher in this study, I took field notes, interpreted these, and used these notes as part of the findings. Also, being a mother who has used health facilities for childbirth, I have my perspectives and opinions. These opinions and views did not, however, bias the analysis and interpretation of the results. I bracketed (set aside) my personal beliefs and biases to bring forth the meanings and descriptions of participants. I also was honest and open early in the research to address any of these biases. Creswell (2014) highlighted the importance of qualitative researchers making known their opinions and prejudices first in the study to control for biases.

The Significance of the Study

Contribution to Knowledge, Practice, and Policies

I focused on an under-researched area regarding the experiences of women using health facilities for childbirth in South Sudan. Skilled attendance at birth and increase

uptake of women for childbirth services at facilities contribute significantly to reducing maternal and newborn deaths globally (Every Women Every Child, 2015; WHO, 2016). Strategies to increase the use of health facilities for childbirth, therefore, could contribute to improving health outcomes for mothers and newborns in South Sudan. Any improvement in the utilization rates of health facilities for delivery will be transformative for the country. It is also a priority of the Government of South Sudan as articulated in the National Health Sector Development Plan (MoH, 2017) to increase the number of women using health facilities for childbirth. Findings from this research could contribute to the development of policies and programs to improve women's experiences giving birth at health facilities and increase uptake of maternity services.

Implications for Social Change

Improved maternal health outcomes by increasing the uptake of health facilities for childbirth could make a difference in the lives of individuals, families, and communities. Two critical elements of social change are mobilizing communities and transformative actions (Kristoff & WuDunn, 2014). Additionally, an improved understanding of this social dilemma related to non-use of health facilities could empower and transform maternal health services in this country. I also engaged women who are essential for social change to occur. This change could only occur with people's participation (Kristoff & WuDunn, 2014). This research, therefore, has the potential for creating real social change in the Republic of South Sudan.

Beneficiaries and Use of Research

Several key stakeholders in the country could benefit from the findings of this study. These stakeholders include policymakers, government officials, and parliamentarians in the country, who are very concerned with the low use of maternity services and could use the findings from this research to develop policies and programs. Development partners and United Nations agencies could also use the results from this research to strengthen technical assistance and programming on maternal health. Health service managers, program implementers, and health care workers including midwives could also use this research to enhance program delivery and strengthen initiatives to increase utilization of maternity services. Further, researchers and academia could do additional research on maternal health services, applying other theoretical frameworks.

Summary

The poor maternal health outcomes and low use of health for facilities for childbirth in South Sudan remain significant concerns for the government of the country (MoH, 2017). This new country faces many challenges with the absence of data and information affecting evidence-based programming (Independent Evaluation of the MDTF-SS, 2013). There is still much speculation and little scientific evidence about the reasons for the low use and non-use of health facilities for childbirth in South Sudan. Anecdotal evidence suggests that there are many contextual and community factors influencing the little use of these facilities by women to give birth (MoH, 2017; UNOCHA, 2016). This research on the experiences of women using health facilities for childbirth could, therefore, contribute to the body of knowledge on the use of health

facilities, which could further assist in the development of programs and policies to improve maternal health in the country.

In this chapter, I outlined the broad introduction to this dissertation research, concluding with the significance of this study and contribution to social change. I used HBM as the theoretical model to guide the direction of this phenomenological study. Further, there are several studies done globally on the use of health facilities for childbirth, allowing this research to contribute by confirming or disproving these previous studies. In the next chapter, I will focus on the past literature, outlining evidence on the use of health facilities including similar peer-reviewed studies grounded in theory. I will describe the gaps in the literature to identify the contribution of this research to new knowledge and the body of evidence on the use of maternity services.

Chapter 2: Review of Literature

Introduction

The purpose of this study was to describe the experiences of women deciding and using a health facility for childbirth in South Sudan. This chapter includes a review of the current literature on experiences using health facilities for birth, the situations, and context facilitating and inhibiting these experiences, and the impact of these factors on the uptake of maternal health services and maternal health outcomes. The birth of a child is usually a joyful time for many women and their families. In South Sudan, however, the high maternal mortality and low skilled attendance at birth result in apprehension at childbirth (MoH, 2017; MoH, & NBS, 2011). I conducted a thorough review of the literature to gain an in-depth understanding of the issue and provide context for this study.

I conducted the literature search using the following databases: CINAHL, Medline, ProQuest Central, ProQuest Health & Medicine, ProQuest Nursing and Allied Health Source, SocINDEX, PUBMED, Academic Research Premier, and Science Direct. I used keywords in my searches such as *maternal health care and childbirth*; *childbirth experiences; perceptions and childbirth*; *use of health facilities and childbirth; childbirth and developing countries; childbirth in Africa*; *childbirth and South Sudan; maternal health and South Sudan; maternal health and developing countries;* and *maternal health and Africa*. I identified and sought relevant studies including those in the press and published. I also searched UN agencies and other development partners' websites for published information and documents. Through the literature search, I found many

related articles and reviews on childbirth and using health facilities but most related to the 'Global South' in Africa and elsewhere. All items were related to giving birth in facilities, at home, or both.

In the first section of this chapter, I will discuss the HBM as a conceptual framework for acting on health issues. I will then explore the literature with regards to the relevance and influence of elements of the HBM to decision making and taking action, mainly related to the uptake of maternal health services and institutional deliveries. In the next section, I will review the literature on maternal health outcomes and institutional deliveries, highlighting global trends related to giving birth in health facilities under skilled supervision. I will discuss the situation in South Sudan, analyzing the literature for the context and identifying gaps with regards to maternal health and institutional deliveries. In the final section, I will explore the research to examine evidence on facilitating factors, hindrances, and women's preferences for institutional deliveries. I will also discuss delivering at home and places other than health facilities, looking at some of the contextual factors, experiences, and challenges.

The Literature on Health Belief Model and Health Facility Delivery

Health education and behavioral theories have been used for many years to predict and analyze decision-making and action (Fishbein, & Ajzen, 1975; Glanz et al., 2015; Hayden, 2017). There have been studies that applied some health education and behavioral theories including the HBM to explain, predict, and analyze factors influencing, and affecting the use of health services (Loke et al., 2015; Mohtasham & Atefeh, 2013; Moudi et al., 2015). In this regard, I applied the HBM in this research to

analyze and explain the experiences of women using health facilities for childbirth in South Sudan.

There is a lack of research on the application of health education theories to describe and analyze women's experiences using health facilities for childbirth. The HBM, however, has been widely used to explain behavior and action (Glanz et al., 2015; Hayden, 2017; Jans, & Becker, 1984), but not entirely utilized regarding childbirth services. I applied all 6 elements of HBM in my research for a deeper understanding of this complex phenomenon.

Review of Literature on Application of HBM

Three U.S. psychologists developed the HBM in the 1950s to address public health concerns at that time, by influencing individual behavior to act to prevent illness (Edberg, 2015; Hayden, 2017; Rosenstock, 1974). Critical elements of HBM have been used to predict behavior and response that women may take related to use of services (Loke et al., 2015; Mohtasham & Atefeh, 2013; Glanz et al., 2015; Rosenstock, 1966). These elements include perceived benefits, disadvantages, severity, cues or prompts, and self-efficacy (Glanz et al., 2015; Rosenstock, 1974).

I found that the HBM elements have varying influence on health behavior and action. Loke et al. (2015) found that perceived benefits, severity, and prompts to acting were significantly associated with women's preference for mode of giving birth. Further, the researcher found that perceived severity of consequences and perceived benefits of acting were all significantly associated with particular positive health behavior (Loke et

al., 2015). There is a need to, however, explore applying the elements of HBM beyond how they influence health behavior and action.

There are six constructs of HBM: (a) perceived susceptibility, (b) severity, (c) benefits, (d) barriers, (e) prompts to action, and (f) self-efficacy (D'Angelo, 2016; Glanz et al., 2015). I applied all of these HBM elements to the experiences of women using health facilities for childbirth. One of the elements of the HBM, self-efficacy, is described as individuals' belief in their ability to act (D'Angelo, 2016; Glanz et al., 2015). High self-efficacy is also strongly associated with the use of health services in other studies (Mohtasham & Atefeh, 2013; Jans, & Becker, 1984). In this study, I explored the impact of self-efficacy on the experiences of women and their plans for the continued use of health facilities for childbirth

Maternal Health Outcomes and Institutional Deliveries Globally

There has been some progress made in reducing maternal deaths globally; however, there are still many countries in the 'Global South' lagging behind (Every Woman Every Child, 2015; Say et al., 2014; WHO, 2015; WHO, 2016). Deaths and disabilities as a result of pregnancy and childbirth remain a severe problem, with lack of skilled attendance at birth, one of the major contributing factors (Every Woman Every Child, 2015; Say et al., 2014; UNFPA et al., 2014; WHO, 2015; WHO, 2016).

There are many reasons for women in the 'Global South' to give birth at home. These reasons include the cost of care, lack of transportation, and perceptions of the quality of care (Bagheri, Alavi, & Abbaszadeh, 2013; Kawakatsu et al., 2014). Additionally, sparse road networks, policies, and cultural barriers are contributing factors

for home deliveries (Exavery et al., 2014; Loke, Davies, & Li, 2015; Moudi, Saeedi, & Tabatabaie, 2015). Globally, women could deliver at home under the care of skilled attendants. In South Sudan, however, traditional birth attendants in communities are illiterate, unskilled, and untrained; giving birth at home poses more risks for these women from complications of childbirth (MoH & NBS, 2011; UNOCHA, 2016).

Institutional Deliveries: Importance and Relevance

Complications arising during pregnancy and childbirth require management by skilled and trained personnel (Every Woman Every Child, 2015; WHO, 2016). These complications, such as obstructed labor, eclampsia, and postpartum hemorrhage, cannot be predicted and may arise at any time and anywhere (Say et al., 2014; WHO, 2015; WHO, 2016). Complications can occur in about 15% of pregnancies with subsequent death or disease to mother and her baby if not managed (UNFPA et al., 2014; WHO, 2016). Institutional delivery is vital among evidenced-based interventions recommended for reducing maternal and infant deaths around the world particularly in the 'Global South' countries (Every Woman Every Child, 2015; UNFPA et al., 2014; WHO, 2015; WHO, 2016).

In South Sudan, it is not easy to manage complications in childbirth because of the limited number of skilled attendants at birth. The State of the World Midwifery Report (2014) outlined a met need for maternal health workers of only 6% and only 307 qualified midwives for an estimated population of 12 million people. Pregnant women in the 'Global South' such as South Sudan are, therefore, encouraged to give birth at health facilities where there is access to skilled personnel, appropriate medical facilities, and

drugs to reduce risks of death or disability if such complications arise during labor (WHO, 2015; WHO, 2016). There is evidence that an estimated 70% of the population in South Sudan have access to health facilities that provide free health services, but the use of these health facilities for childbirth remains low in the country (MoH, 2013).

Maternal Health Services and Outcomes in South Sudan

The South Sudan Ministry of Health manages maternal health services through a four-tiered public health care system with the lowest level being Primary Health Care Units (PHCUs) and the highest at State and Teaching Hospitals (MoH, 2017; Mugo et al., 2015). MoH (2017) revealed that about 44% of the population lives close to a functional health facility. South Sudan, however, has some of the worst maternal health indicators including an increased lifetime risk of dying during pregnancy and childbirth (Kolok, 2013; MoH, & NBS, 2011; NBS, 2013; WHO et al., 2015). The conflict and humanitarian situation in the country also continue to contribute to a dire situation for women by further reducing access to maternal health care (Green, 2014; Kolok, 2013; Mugo et al., 2015; WHO, 2017).

Childbirth and Use of Health Facilities in South Sudan

In South Sudan, an Emergency Obstetrics and Newborn Care (EmONC) Needs Assessment in 2013 revealed that 65% of health facilities performed deliveries and 79% of all facilities surveyed provided antenatal care services (MoH, 2013). It is, however, a rare occasion for women to give birth in a health facility with evidence showing that only 11.5% pregnant women reported giving birth in health facilities (MoH, & NBS, 2011). The EmONC Needs Assessment also revealed that only 4% of births took place in

facilities providing emergency obstetric and newborn care services when analyzed at a national level (MoH, 2013). At the state level, this situation was, even more, alarming with institutional deliveries in EmONC facilities being as low as 0.5% (MoH, 2013). The absence of trained birth attendants in the community, and with many village midwives unable to read or write, home deliveries could compromise maternal health outcomes in this new country.

Maternal Health Care and Challenges in South Sudan

Maternal health indicators for South Sudan are poor, with evidence of high levels of fertility, low contraceptive use, high numbers of teenage pregnancies, and women having a 1 in 7 chance of dying during one of their pregnancies or childbirth experiences (MoH, & NBS, 2011; NBS, 2013). MoH (2017) acknowledged that there are many challenges with the health care system in the country, which results in the low uptake of services. These problems include the poor quality of services and care provided to clients, and the lack of equipment, drugs, and supplies (Independent Evaluation of the MDTF-SS, 2013; Johnson et al., 2013). Other factors were poor infrastructure including lack of roads and inadequate water supply, and the absence of skilled staff (Independent Evaluation of the MDTF-SS, 2013; Johnson et al., 2013; Kolok, 2013; MoH, 2017). The frequent upsurge in fighting and violence has also resulted in many displaced people, including pregnant women, not accessing maternal health services (Green, 2014; UNOCHA, 2017; WHO, 2017). Little is known, however, about the experiences of women who obtain maternal health services with data systems still weak (Johnson et al., 2013; MoH, 2017). Research on health facility delivery globally will help understand this phenomenon. It is

not clear, however, that all findings are applicable and can explain the situation in South Sudan.

Health Facility Delivery: Challenges and Opportunities

Many studies encourage women to give birth in a health facility under the care of skilled personnel for better health outcomes for mother and baby in the Global South (Abeje, Azage, & Setegn, 2014; Kawakatsu et al., 2014; Wilunda et al., 2014). Research has shown that with high skilled attendance at birth, there is a reduction in maternal mortality in some countries (Exavery et al., 2014; Kruk et al., 2014; Moudi et al., 2015; Sat et al., 2014; Wilunda et al., 2014;). Interventions to increase institutional deliveries in the Global South could, therefore, contribute to reducing maternal deaths and disabilities (UNFPA et al., 2014; WHO, 2016). There are, however, many facilitating and hindering factors for institutional deliveries noted for countries in Asia and Africa (Abeje et al., 2014; Bagheri, Alavi, & Abbaszadeh, 2013; Kawakatsu et al., 2014). These factors would be further explored in the literature for relevance and to later confirm or disprove in the context and applicability in South Sudan.

Preferences and Facilitating Factors for Health Facility Delivery

There are many studies on influences for institutional deliveries (Abeje et al., 2014; Onta et al., 2014; Exavery et al., 2014; Kruk et al., 2014; Moudi et al., 2015; Wilunda et al., 2014). Fear of complications during childbirth has been shown to influence many women’s decision to go to facilities to give birth (Bagheri et al., 2013; Cofie et al., 2015; Kawakatsu et al., 2014). No data exist, however, for South Sudan regarding successful versus unsuccessful home deliveries. Many women and girls give

birth at home with unskilled attendants, contributing to the high rate of maternal deaths and disabilities in the country (MoH, 2017; MoH, & NBS, 2011). Previous experiences with complications during childbirth and knowledge of family members and friends having such difficulties have been highlighted as crucial factors influencing some women giving birth at health facilities (Onta et al., 2014). Women's preferences and use of health facilities were associated with several demographic characteristics such as residing in urban areas or close to health facilities (Chukwuma et al., 2017; Enuameh et al., 2016; Kruk et al., 2014). Other factors observed were having an education (Abeje et al., 2014; Kawakatsu et al., 2014; Kruk et al., 2014) and women with first-time pregnancies (Abeje et al., 2014; Kawakatsu et al., 2014). These factors worked in reverse to affect the use of childbirth services at health facilities and may be applicable in the context of South Sudan.

Obstacles and Hindrances to Health Facility Delivery

Overcrowding of health facilities, lack of privacy, high cost for transportation, and other perceived financial expense at a health facility were found to be significant barriers to using health facilities for childbirth (Kawakatsu, et al., 2014; Moudi et al., 2015; Onta et al., 2014). Further, Onta et al. (2014) found that despite living close to health facilities, women were ashamed of using these facilities for childbirth, contributing to the low uptake of services at health facilities.

Sociocultural issues such as uncomfortable birth position and too much invasive procedures such as vaginal examinations played a role in women deciding against using facilities for childbirth (Diamond-Smith, & Sudhinaraset, 2015; Moudi et al., 2015;

Wilunda et al., 2014). Abuya et al. (2014) explained the disrespect and abuse women experienced accessing maternal care including the absence of private, consensual, and dignified care being factors affecting their use of facilities. Neglect and abandonment during delivery were also highlighted as hindering the use of health facilities (Enuameh et al., 2016; Abuya et al., 2014). These factors should be explored in this research to understand the situation and context in South Sudan.

These studies have identified factors influencing and affecting the use of health facilities for childbirth, but there is still little information available on the actual experiences of women at these facilities. Information on women's interactions with the healthcare provider, other women using the facilities, their feelings on arrival, and their descriptions of their experiences giving birth in these health facilities could be useful, therefore, in understanding this complex phenomenon. This information may also offer insights into new ways to organize services which could enhance the experiences of women and contribute to increasing uptake of maternal health services.

Home Deliveries: Issues and Perspectives

Women giving birth at home have been a frequent phenomenon for centuries. There is evidence that women preferred home deliveries as it allowed them to be in a comfortable environment, the privacy of their homes, and among family members for support (Exavery et al., 2014; Moudi et al., 2015; Mason et al., 2015). Researchers also found that available community health workers and traditional birth attendants also contributed to some women delivering at home under their care (Exavery et al., 2014; Onta et al., 2014; Wilunda et al., 2014). Researchers, however, found that despite efforts

made by community health workers to conduct home visits and refer women to health facilities for childbirth, institutional deliveries did not increase (Kawakatsku et al., 2014). In another instance, community awareness interventions, providing education, and sensitization sessions on the advantages of hospital deliveries were shown not to have reduced home deliveries nor increase institutional deliveries (Brazier et al., 2014; Cofie et al., 2015). In this regard, I will explore more comprehensively, the experiences of women in South Sudan with institutional deliveries to understand women's preferences in the choice of delivery sites and reasons for low use of facilities for childbirth.

Summary

I reviewed and analyzed the literature related to using health facilities for childbirth to help understand this phenomenon and to identify gaps in the literature for further research and exploration. Poor maternal health outcomes and low use of health for facilities for childbirth in many countries, particularly in the global south remain an area of concern, particularly in fragile states such as South Sudan (Green, 2014; Kolok, 2013). South Sudan continues to experience a high number of home deliveries with unskilled attendants or alone, low use of facilities for childbirth, and high numbers of maternal deaths and disabilities (MoH, & NBS, 2011). Interventions to increase the uptake of skilled attendance at birth and use of health facilities for childbirth are considered crucial actions that could contribute to reducing maternal deaths and disabilities by providing women with access to medical personnel and the necessary facilities for managing complications in pregnancy and childbirth if they arise (WHO, 2015; WHO, 2016).

Researchers found several factors influencing and hindering the use of health facilities for childbirth such as cost, sociocultural factors, transportation, and fear of death or complications (Kawakatsu et al., 2014; Moudi et al., 2015; Onta et al., 2014). Other researchers found that efforts at addressing these barriers had not increased the use of health facilities for childbirth (Brazier et al., 2014; Kruk et al., 2014; Mason et al., 2015). No specific study in the literature review, however, included the issue of women's experiences using health facilities for childbirth. Greater understanding of this phenomenon could, therefore, contribute to better programs and services for women during the delivery. Research in this area could also assist in developing effective policies to guide service delivery and the design of maternal health services.

In the next chapter, I will discuss the research methodology, justifying the research design and the use of phenomenology. I will further outline the sampling strategy; describe the data collection and analysis process including the use of structured and semi-structured interviews. I will discuss some keys aspects related to my research as a qualitative study, in particular, the strategies that I used to gain access to participants. I will also explain some of the ethical issues I considered during my research including the benefits and risks of the study to participants.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to describe the experiences of women using health facilities (hospitals or health center) for childbirth. The previous chapter included a review of the literature on maternal health outcomes and facility deliveries. The literature revealed that skilled care at birth could reduce maternal deaths but progress in achieving this maternal mortality reduction remains a challenge for the Global South (Every Woman Every Child, 2015; Exavery et al., 2014; Kruk et al., 2014; WHO, 2016; Wilunda et al., 2014). The studies that I reviewed focused on factors influencing, and hindering use of facilities for childbirth (Bagheri et al., 2013; Exavery et al., 2014; Kawakatsu et al., 2014; Kruk et al., 2014; Moudi et al., 2015; Wilunda et al., 2014). None of the researchers, however, focused on the experiences of women giving birth at these facilities.

In this chapter, I will present the research methodology and justification for this qualitative study. In the first section, I present the research design, outlining the research central question and sub-questions. Then I will explain the role of the researcher, highlighting any relationship biases and the management of these biases. In the following sections, I will discuss the methodology, identifying the sample, sampling strategy, the instrument used, recruitment of participants, data collection, and data analysis. In the final section, I will discuss ethical issues and conclude with a summary and transition statement.

Research Design and Rationale

Central Phenomenon and Research Questions

The central phenomenon in this phenomenological study was the experience of pregnant women deciding and using a health facility for childbirth. I used the HBM as the theoretical foundation for this study. Creswell (2014) explained that phenomenology provides more profound descriptions and complete information on lived experiences with a complicated issue. The Government of South Sudan has highlighted that increasing uptake of women using health facilities for childbirth is a national priority (MoH, 2017). I conducted a phenomenological inquiry, to answer and clarify issues related to childbirth in health facilities for a deeper understanding of this problem.

The central research question for this study was: What are the experiences of women using a health facility (hospital or health center) for childbirth in South Sudan?

The following subquestions aided me in answering the central question:

- What are the context(s) and situations that influence women to decide and use a health facility for childbirth?
- What are the context(s) and situation(s) that prevented women from deciding and using a health facility for childbirth?
- How have women described their experiences of childbirth in health facilities in South Sudan? What are some of the reasons women give for their descriptions of the experiences?

Role of the Researcher

I was a participant-observer in this research. I planned on interviewing the participants, making comments, and asking questions. I took field notes during the interview process on my observations and any non-verbal cues. I used this, together with member checking and computer-generated analysis for comparison and triangulation of the data which is useful for ensuring data quality. I did not allow my role as a researcher to influence or impact on study participants.

In qualitative research, it is always essential for researchers to provide information on their biases or opinions (Creswell, 2014; Creswell & Poth, 2018). This information helps in setting aside (bracketing out) those feelings and perspectives so that those of participants become paramount (Creswell, 2014). I am employed in South Sudan with one of the United Nations Agencies, working in the field of maternal health. I have, therefore, observed the plight of women staying at home to give birth. I am also a mother of one child who has given birth in a health facility. These factors did not affect my understanding and analysis of the information garnered through this research but should contribute to more comprehensive questions and better explanations and interpretations of this phenomenon.

Methodology

I made decisions on the people, sites, approaches, and strategies to be used to collect data, which is critical when conducting qualitative research. My research question was best answered using the phenomenological approach and applying the theoretical

construct of the HBM. I used all of the constructs of HBM for analysis and interpretation of the information shared by women on their experiences using facilities for childbirth.

Participants' Recruitment and Selection

I conducted in-depth interviews with 20 women between the ages of 18 and 35 who would be delivering at the Juba Teaching Hospital. I used purposeful sampling with the support of the midwife in charge at the hospital. The midwife manager provided the list of women over 18 years of age in the hospital who were about to deliver or just delivered, and I chose a diverse sample from this list. For this sample, my criteria for selection included women who had given birth at home or in the hospital with a previous childbirth experience for more productive and more in-depth discussions of this issue. I also chose women from at least four of the main ethnic tribes in the country. I decided on participants of varying age, locations, and parity. I included among the criteria women who had never given birth previously. This sample variation assisted with data triangulation and comparison of the information.

I invited the 20 selected women to participate, received their voluntary consent, and agreed to meet and interview them when they returned for follow up and registration, one to two weeks after delivery. I chose a small sample because it is advantageous, allowing more in-depth information which is vital for phenomenology. Marshall & Rossman (2016) explained that a large number of interviews might limit the richness of the data collected.

Data Collection and Instrumentation

I developed an interview protocol using open-ended questions in a structured manner to collect information from study participants. I designed this protocol based on my literature review and the research subquestions. I also received the necessary information from participants on their demographic profile including age, ethnic group, address, and parity among others. I used the interview protocol to probe and to get the required information.

I conducted face-to-face in-depth interviews with 20 women for my research, which is a conventional method used to collect data in the phenomenological inquiry. The in-depth interview is the communication between or among one or more persons on a specific issue and is useful for providing complete information (Creswell, 2014; Creswell & Poth, 2018; Marshall & Rossman, 2016). Most of the interviews lasted for approximately 90 minutes. I conducted interviews in English in a private room at the clinic at the hospital. I also requested any available audio, visual materials, or documented information from participants. I offered the participants the opportunity to take a break during the interviews, but all participants declined to take a break. I recorded the conversations, made field notes, and observations.

I completed all the interviews at the scheduled time with participants. I collected contact information from them in case I needed to make a follow-up with them to clarify any of the information they provided to me. I had to contact two of them by telephone again about 3 weeks after the data collection to explain some of their responses. I was able to discuss and clarify some of their responses. I used my closure statement from the

protocol, thanking the respondents for their participation and providing them with my telephone number in case they had further questions or any concern. None of the participants contacted me on any further questions or concerns they had.

Data Analysis

A critical analysis of interviews in qualitative studies usually requires planning and organization of the vast amount of information generated and stored (Creswell, 2014; Creswell & Poth, 2018; Marshall & Rossman, 2016). I used a voice recorder during the interviews, and I transcribed the information. I worked with one colleague whom I trained to assist with the transcribing and reviewing of the data. All transcriptions were checked for correctness and as part of the data quality control. I rechecked with two participants to clarify information they provided during the interview. I made observations, comments, and word descriptions in my notebook. I checked the field notes and compared this with the transcriptions for accuracy and quality. I stored all information confidentially in a locked drawer and password protected disk.

For the data management, I hand-coded the data first, developing broad themes and subthemes from questions in the interview protocol and linkages to the research sub-questions. Each interview protocol question was linked with the research sub-question and also with an element of the HBM. I hand-coded the data before computer coding. Saldana (2016) stated that handcoding of the data helps to sort out the data and efficiently process this data for analysis. I also aligned the general and subthemes with the elements of the theoretical construct, the HBM. I checked the transcribed data, chose some responses, and reviewed how well the alignment was with the broad statements, research

questions, and the theoretical construct. After importing data in NVivo, I used the general themes developed as parent nodes and generated child nodes for the subthemes. NVivo allows for proper storage and control of the data (Creswell, 2014; Hilal & Alabri, 2013). Together with my assistant, I sorted and classified the data for triangulation and also to reduce the large volume of data. I then filtered and analyzed the data, highlighting similar statements made by the participants and for any discrepant phrases. These phrases were later reclassified based on the linkages developed with the research questions. I rechecked some information manually to verify expressions and some key highlights from participants. I completed backup copies and developed a master list to ensure proper storage of data and prevent data loss.

Ethical Issues and Trustworthiness

The soundness of the data collection and analysis process will influence and determine the trustworthiness and quality of the data (Creswell, 2014; Creswell, 2016). I used multiple methods to compare the data for correctness and to ensure data quality. I continually reviewed the data and rechecked transcribed documents to ensure accuracy and correct errors. This review provided data quality and trustworthiness of the research. I collected field notes during the research process which I stored confidentially. I also set aside (bracketed) my feelings and perspectives on the issue.

I conducted this study with human subjects, so I maintained ethical standards and did not compromise the rights of participants. I conducted this study among adults and sought their informed consent to participate in the research. Only participants who give permission were involved in the study. Creswell (2014) stated that it is essential to

respect the right of any respondent to decline to be interviewed. I collected primary demographic data from participants after their consent and stored this confidentially. I sought permission from the health facility administration to enter and use the facility for interviews, ensuring that I used available room and space for privacy.

I sought permission and approval from two committees, completing the necessary forms for approval. I submitted my research proposal to the Institutional Review Board (IRB) of the Walden University and received approval (number 06-06-17-0428018) for the conduct of my study. South Sudan also has a national Research Committee based at the Ministry of Health that reviews all research to be conducted in the country and approves the proposal for implementation. I submitted my research proposal and received approval from this body. Further, I shared my opinions and biases so that participants' views could come forward. I maintained all ethical standards that must be adhered to for my research to be credible and trustworthy.

Summary

I conducted a phenomenological study to allow for more in-depth understanding and a more detailed explanation of this complex issue. I used structured interviews with the interview protocol as the primary form of data collection, as expected of phenomenology. I used a small sample of 20 women because it was not necessary to have a representative sample but one which would allow adequate time to get detailed information on the phenomenon. I ensured that the data is stored well and coded the data both by hand and computer using NVivo software. NVivo is useful for data management and analysis, with proper conceptual mapping features for presentation and analysis

(Hilal & Alabri, 2013). Finally, I ensured that my research met ethical standards by submitting my study for approval through the right mechanisms and I protected the rights of all participants by maintaining confidentiality and their voluntary consent to participate in this study.

In the next chapter, I will analyze and present the findings from my research, providing a graphic display of the results. I will summarize the data collection and analysis process used, explaining how this fits within the overall theoretical framework. I will also outline the findings under broad themes and classifications. I will present the demographic profile of participants and discuss the results regarding the data collected and analyzed. I will explain all the discrepancies, and finally, I will provide a summary of the answers to the research questions.

Chapter 4: Results

Introduction

In this study, I describe the experiences of women using health facilities for childbirth. The previous chapter included the research methodology and justification for this study. The research design was a phenomenological study, using HBM as the theoretical framework for a deeper understanding of these experiences of women using health facilities for childbirth.

The central research question for this study was: What are the experiences of women using a health facility (hospital or health center) for childbirth in South Sudan?

The following subquestions aided me in answering the central question:

- What are the context(s) and situations that influence women to decide and use a health facility for childbirth?
- What are the context(s) and situation(s) that prevented women from deciding and using a health facility for childbirth?
- How have women described their experiences of childbirth in health facilities in South Sudan? What are some of the reasons women give for their descriptions of the experiences?

In this chapter, I will present the results and findings of this study. In the first section, I will discuss the research setting, outlining some contextual factors that could have affected this study and its interpretation. I will then present the participants' demographics and characteristics relevant to the study. In the next section, I will describe the data collection process, including the sampling strategy and the participants'

selection. I will discuss data analysis, presenting the management of the data and the broad themes that emerged. I will also describe elements of trustworthiness. In the final section, I will present the results that emerged from this study by general statements, using tables and quotations to illustrate these results

Setting

I conducted this study in Juba, the administrative capital of South Sudan, with all participants delivering at the Juba Teaching Hospital, which is the premier government managed health facility in the country. Despite being considered the premier healthcare institution, this hospital is experiencing significant challenges including lack of health supplies and human resources. Healthcare services are free but have been much affected due to the lack of funds by the government to provide necessary health supplies and pay the salaries of health workers (International Monetary Fund [IMF], 2017; WHO, 2017).

The Republic of South Sudan is in a severe economic crisis, with an annual inflation rate that rose to 550% in September 2016 and the local South Sudanese currency depreciating more than 95% of its value against the United States dollar (IMF, 2017). This situation has resulted in widespread food insecurity with famine declared in some parts of the country and is a critical humanitarian situation (IMF, 2017; WHO, 2017). The population is significantly affected by this crisis, with many women seeking services at hospitals complaining of hunger and lack of funds to purchase food. The recent internal conflict in July 2016 has also contributed to higher feelings of insecurity among the general population (WHO, 2017). This situation may have impacted this research as many participants reported feeling insecure and cited lack of food in their responses. This

issue may, therefore, be much more significant in the results and interpretations of these findings at this time.

Demographics

I sampled participants for this study from diverse ethnic tribes and location in South Sudan. These participants also varied in age, education level, and previous births that they experienced. This diverse group of participants allowed for more in-depth, more vibrant discussion, and understanding of this phenomenon. Table 1 below includes vital demographic information on all respondents who participated in this study. All participants were 18 years and over so were able to provide voluntary consent.

Table 1

Table Showing Demographic Data of Respondents

	Age (Years)	Ethnic Tribe	Education Level	Marital Status	Place of Birth	Employment Status	Previous Births	Number in Household
01	24	Madi	Primary	Married	Nimule	Unemployed	2	9
02	22	Kakwa	Secondary	Married	Juba	Unemployed	0	9
03	19	Dinka	Primary	Married	Abyei	Unemployed	0	8
04	18	Pojulu	Primary	Married	Lainya	Unemployed	1	7
05	32	Dinka	Primary	Married	Bor	Unemployed	3	6
06	28	Pojulu	Primary	Married	Lainya	Unemployed	2	8
07	28	Bari	Primary	Married	Juba	Unemployed	9	11
08	18	Bari	Secondary	Married	Juba	Unemployed	0	8
09	26	Bari	Primary	Married	Juba	Unemployed	6	8
10	18	Kakwa	Primary	Married	Yei	Unemployed	0	8
11	27	Dinka	Secondary	Married	Aweil	Unemployed	4	7
12	33	Dinka	Secondary	Married	Aweil	Unemployed	4	8
13	18	Kakwa	Secondary	Married	Yei	Unemployed	0	8
14	24	Kuku	Secondary	Married	Kajo Keji	Unemployed	0	2
15	22	Kakwa	Primary	Married	Yei	Unemployed	0	2
16	29	Dinka	Secondary	Married	Dinka	Unemployed	4	8
17	22	Bari	Secondary	Married	Juba	Unemployed	4	7
18	18	Nuer	Primary	Married	Bentiu	Unemployed	0	5
19	20	Mundari	Secondary	Married	Terekeka	Unemployed	1	5
20	20	Kuku	Primary	Married	Kajo Keji	Employed	0	2

The respondents varied by age, ethnic tribe, place of birth and the number of previous births they had before this birth. All respondents were married, and only one

respondent stated that she was employed. Most of the respondents were also in households with over five persons. Participants also either completed primary or secondary education. No participant had university or tertiary level education.

Date Collection

I decided on the people, sites, approaches, and strategies to be used to collect data, which is crucial when conducting qualitative research. I chose a small sample since this is advantageous, allowing more in-depth information which is vital for phenomenology as a large number of interviews may limit the richness of the data collected. I developed the interview protocol, which included 25 open-ended questions. After receiving approval from the IRB (number 06-06-17- 0428018), I discussed with hospital administration on my research, and I received permission. The hospital management team also gave their support of my study to commence at any time. I conducted all in-depth interviews myself for this qualitative study in English.

Participants' Recruitment and Selection

I conducted interviews with 20 women between the ages of 18 and 35, who had experienced the phenomenon of delivering at the Juba Teaching Hospital during the two month period of July and August 2017. I interviewed all 20 participants selected. I used purposeful sampling with clear criteria which included women who had given birth at home or in the hospital with a previous childbirth experience for more in-depth discussion of this issue. I also chose women from eight ethnic tribes in the country. I decided on participants of varying age, locations, and parity. I included women who had never given birth previously. I also interviewed women who could speak English. I

selected participants with the assistance of the In Charge at the Maternity Unit of the Juba Teaching Hospital. The midwife manager provided the list of women over 18 years in the hospital who were about to deliver or just delivered, and I chose a diverse sample from this list. I contacted participants at the hospital, after delivery, and their consent sought. I then conducted a follow up with them for the interviews based on our agreement when they returned to the clinic for follow up, registration, and vaccination.

Data Collection and Instrumentation

I conducted in-depth interviews for my research, which is a standard method used to collect data in the phenomenological inquiry. Most of the in-depth interviews were conducted 3 to 7 days after delivery, during their follow-up visit for registration and early vaccination for their newborn babies. I used a private room at the hospital to interview women confidentially. Interviews were voice recorded and lasted 60 to 90 minutes, using the prepared interview protocol. I conducted interviews in English and all at once. There was no variation in the interview protocol as approved by the IRB. I also did not make changes in the data collection process from the plan. I recorded the conversations and made field notes and observations

I developed an interview protocol, using open-ended questions to collect information from study participants. I designed this protocol based on my literature review and the research subquestions. I asked a wide range of questions about this topic to allow participants to provide genuine responses. I used the interview protocol questions to probe and to get the required information. I asked participants to provide any available audio, visual materials, or documented information but did not receive any from

participants. I offered participants the opportunity to take a break during the interviews, but all participants declined this interview break. I collected contact information from participants in case I needed to make a follow-up with them to clarify information. I contacted two of them by telephone about 3 weeks after the data collection to explain some of their responses. I also provided them with my telephone number in case they had further questions. None of the participants contacted me on any further questions or concerns.

Data Analysis

I generated a large volume of data from this research which I manage through recording on a voice recorder and transcription of the data. After transcription of the data and member checking by a colleague for accuracy and data quality, I completed hand coding of the data into broad themes. I used the interview questions before importing data in NVivo software for data management and analysis. I completed backup copies and developed a master list to ensure proper storage of data and prevent data loss. I kept my field notes in a locked drawer, and I kept all electronic information on a password protected flash disk. I checked the field notes and compared this with the transcriptions for accuracy and quality.

In managing the data, I hand-coded the data first, developing broad themes and subthemes from questions in the interview protocol and the research sub-questions. I identified several broad themes and categorizations from items in the interview protocol which I used as codes. These general statements were further broken down into subthemes. I also aligned the categories that I developed with the elements of the

theoretical model, the HBM. I reviewed several essential phrases and statements made by respondents and checked their alignment with these themes and subthemes identified, to establish links and relationships for the analysis. I also compared some of the comments from participants with the elements of the HBM.

I imported the data to NVivo. I used the broad themes as parent nodes and subthemes as child nodes. I used NVivo 10 for data management and analysis. I used the texts and labels during this coding process so that I could quickly retrieve the data and make comparisons and similarities. I was able to filter and analyze the data, highlighting similar statements made by the participants and any discrepant phrases. These phrases were reclassified manually based on the questions in the interview process, their alignment with the research subquestion, and the HBM element. For the report, I ran several matrices and queries using the responses of participants for categorization within the broad statements and subthemes. I also reviewed the summary and reference pages of all texts and comments coded from the interviews. I rechecked some information manually to verify expressions and some key highlights from participants.

Evidence of Trustworthiness

I used multiple methods to compare the data for correctness, to ensure data quality, and trustworthiness. I reviewed the data and rechecked transcribed documents to ensure accuracy and correct errors. I also compared data with my field notes and observations. I made telephone calls and followed up with two participants to clarify some information that was not clear in the transcribed document. I also used a colleague whom I trained to review and check the data to ensure consistency and credibility of the

research. The samples are small in qualitative studies and are not representative of the population (Creswell, 2014). The results are, therefore, not transferable to the general population but allow for a more in-depth understanding of this phenomenon.

I conducted this study with human subjects and ensured that participants provided written consent using the consent form approved by IRB. I assigned codes to all participants using numbers between 01 and 20. I also requested and was granted official approval from hospital authorities to collect information from participants at the hospital. I kept all information stored confidentially, in a locked drawer and on a password-protected disk. I also sought and received permission and approval from the Institutional Review Board of the Walden University and the South Sudan Research Committee based at the national Ministry of Health. I maintained all ethical standards that must be adhered to for my research to be credible and trustworthy.

Results

I coded the 25 questions in the interview protocol into five broad themes. I classified these into subthemes and categories under these more general themes. I established linkages with the six elements of the HBM, the theoretical framework used for analysis in this research. Figure 1 below, provides a pictorial representation of the relationship between broad themes and subthemes with the elements or constructs of the HBM. All elements of the HBM were applied and aligned with the broad themes and subthemes.

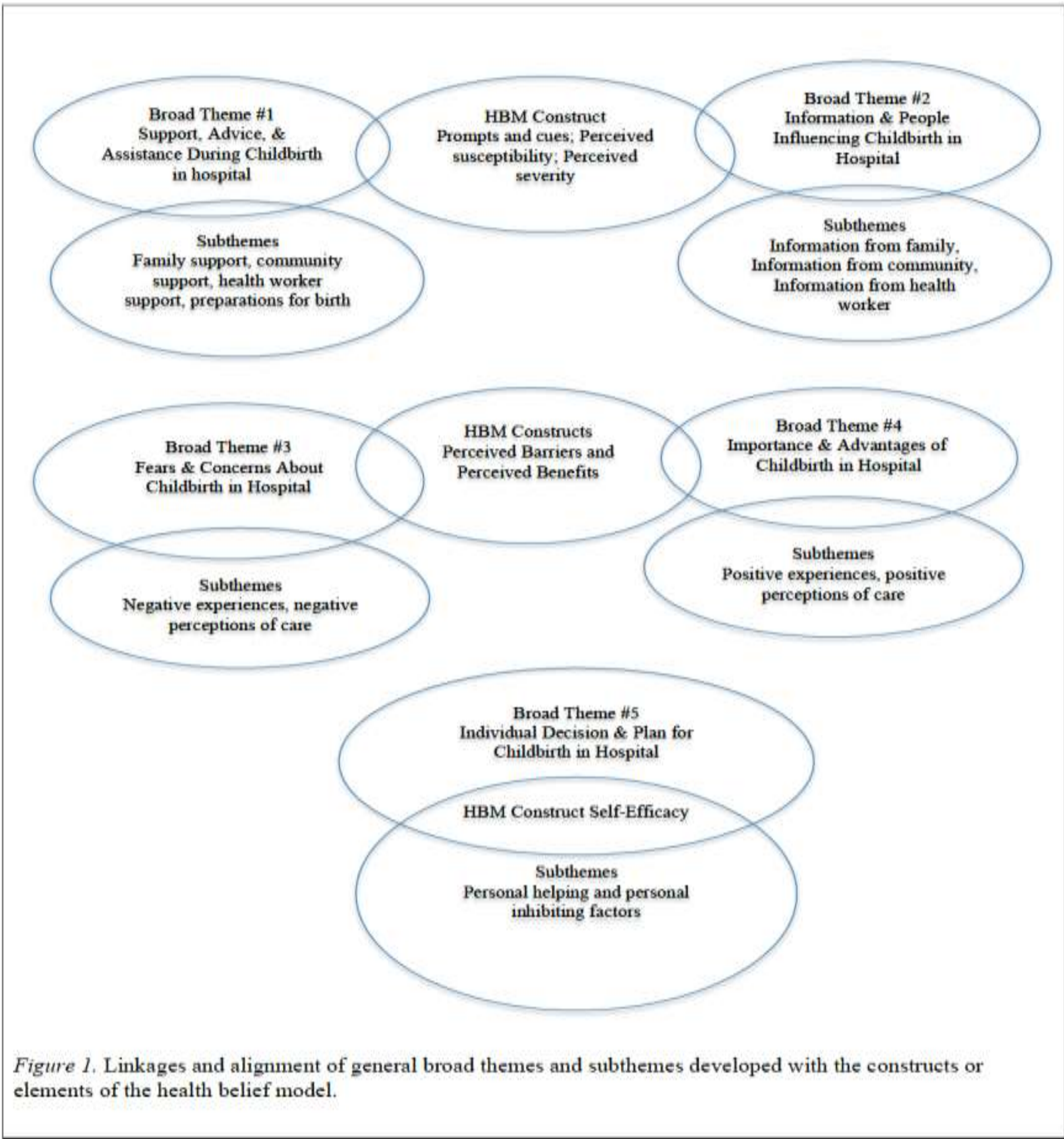

Figure 1. Linkages and alignment of general broad themes and subthemes developed with the constructs or elements of the health belief model.

I linked the broad themes, subthemes, and HBM constructs with all questions from the interview protocol. Table 2 below shows all linkages with the interview protocol questions.

Table 2

Table Showing Broad Themes, Subthemes, Linkages with Interview Questions, and Elements of HBM

Broad themes	Subthemes	Interview Questions	Elements of HBM
Support, assistance, and advice during pregnancy and childbirth in a hospital	Family support, community support, health care worker support, and preparations for the birth	2, 3, 7, 8, 9, 14, 17,25	Cues and prompts to act
Information and people influencing childbirth in the hospital	Previous childbirth, information from health workers, and additional information received from family and friends	4, 5, 6	Perceived susceptibility; Severity of consequences
Fears and concerns about childbirth experience in hospital	Negative perceptions of care, negative experiences	12, 13, 15, 16, 18, 19	Perceived barriers.
Importance and advantages of childbirth in a hospital	Positive perceptions of care, positive experiences	12, 13, 15, 16, 20, 21, 23	Perceived benefits,
Individual decision and plan for childbirth in hospital	Personal helping factors and personal inhibiting factors	10, 11, 22, 24	Self-efficacy

Interview Questions and Emerging Themes

The first broad theme was, "Support, assistance, and advice during pregnancy and childbirth in a hospital." Interview questions were related to what support, assistance, and advice women received from their family members, community, and health service provider. Other items were the preparations women made before the onset of childbirth and in discussion with health workers. The subthemes included family support, support from neighbor and community, health care worker support, and preparations made or provided before childbirth. I aligned the broad theme to the research on the context and situations that influence women to use health facilities for childbirth.

The second broad theme was: "Information and people influencing childbirth in a hospital," and I aligned this to the first research subquestion on the context and situations

that influence women to use health facilities for childbirth. This second general theme was categorized based on questions related to women's previous experiences of childbirth and what information they received on delivery at antenatal care clinics, and during pregnancy that influenced then to give birth in a hospital. The subthemes identified were previous childbirth experience, information obtained from health workers, and additional information collected from family and friends.

The third broad theme was: "Fears and concerns about childbirth experience in the hospital." This theme was identified based on the questions related to women's experiences traveling to access to childbirth services at the hospital, their feelings on the services they received from a midwife or healthcare worker at the hospital, and women's experiences in the hospital for childbirth. This third theme responded to the research subquestion on the context and situations that prevent women from deciding and using a health facility for childbirth. Women also responded to what they least enjoyed about their experiences in the hospital. The subthemes were negative feelings of care received in the hospital, negative experiences going to and in the hospital.

The fourth broad theme was: "Importance and advantages of childbirth in a hospital." This fourth theme, I aligned with the research subquestion related to how women described their experiences of childbirth in a health facility. This broad theme was identified based on questions related to how comfortable women were in the hospital setting, the service they received from the midwife or health worker, and the care provided to their newborns. Women also responded to what they most enjoyed about

their childbirth experiences in the hospital. The subthemes were positive feelings of care received in hospital, positive experiences going to, and while in the hospital.

The final broad theme was: “Individual decision and plan for childbirth in a hospital.” This statement, I aligned with the research subquestion related to the reasons women provided for their descriptions of their childbirth experiences. This final broad categorization was related to the interview protocol questions on what actions women made to decide and use the hospital to give birth and whether they will return if pregnant again. Other questions included whether they will tell someone to give birth in a hospital and what factors would prevent them from using hospitals to give birth in future pregnancies. The subthemes were personal facilitating factors and personal inhibiting factors to giving birth in the future in a hospital.

Theme 1: Support, Assistance, and Advice during Pregnancy and Childbirth in a Hospital

All participants reported a vast network of support, assistance, and advice during pregnancy and childbirth that influenced their decisions and experiences in the hospital. Women said that family members, in particular, their husbands, and mother in law played a crucial role in providing support for them to go to the hospital and their childbirth experiences in the hospital to deliver their babies. Neighbors were also reported as helpful and supportive throughout the childbirth experience for six participants.

Participant 03 stated, “My husband has been good, and he told me that I must go for hospital to get baby because the wife of his friend died at home from bleeding.” Participants 08, 10, 17, and 18 also shared similar stories of support and encouragement

from their husbands. Participant 18 explained, “My husband works with NGO, and he wanted me at hospital because he didn’t want anything to happen to me and the baby.” Fourteen participants reported significant support from their husbands to go to the hospital and during their childbirth experience there. These included the five youngest participants (those women in the study who were 18 and 19 years old).

Participants highlighted that neighbors were helpful and assisted them during their childbirth experiences by taking them to the hospital in taxis, accompanying them, caring for their other children while they went for childbirth, and by bringing food and water for them after they had given birth. Participant 12 explained, “My neighbor brought me to hospital on his *bodaboda,* and he know we have no money, so he don’t ask for any.” This statement was similar to that mentioned by participant 17, “My neighbor is good since she came with me to hospital and then brought back some rice and beans for me because I did not eat anything and was very hungry.” Participant 05 also said the same, “My neighbor told me go to hospital when I started pain, and she looked my children for me.”

Ten participants also reported receiving support and assistance from other family members including parents, siblings, and their older children. Participant 05 explained that her older children took care of the young ones and this allowed her to go to the hospital to give birth. She stated, “I didn’t want go hospital because I got many children, but my firstborn is 17, and at school, they told her about women dying in pregnancy, so she keep telling me to get this baby at hospital.” Participants 01, 16, and 20 also reported on the support they received from their mother, sister, and brother respectively. Seven of the nine participants who were experiencing birth for the first time said that their mothers

encouraged them to go to the hospital and provided much support and care for them during childbirth at the hospital.

Theme 2: Information and People Influencing Childbirth in Hospital

All 20 participants reported receiving information from health workers at the clinic, their families, community, and friends that influenced them to go to the hospital for childbirth. All participants reported attending the antenatal clinic at least four times, except participant 11 who attended clinic three times. Three participants did not plan on giving birth in a hospital, but they stated that they were told by family and midwives at the clinic to go to the hospital for childbirth which they did. Table 3 shows the plan and influences of respondents on their childbirth experience in the hospital.

Table 3

Table Showing Influences among Respondents on Childbirth Experiences in a Hospital

	Previous Pregnancies	Age (Years)	Place of last childbirth experience	The planned site for childbirth	Influences on the decision for childbirth in the hospital
07/01	2	24	Hospital	Hospital	Midwives at the clinic, husband
07/02	0	22	No previous birth	Hospital	Midwives, family members
07/03	0	19	No previous birth	Hospital	Midwives, mother in law, husband
07/04	1	18	Hospital	Hospital	Husband, Family members
07/05	3	32	Hospital	Hospital	Was a health worker, husband
07/06	2	28	Home	Home	Had triplets and one delayed
07/07	9	28	Hospital	Unsure	Previous childbirth difficult
07/08	0	18	No previous birth	Hospital	Midwives, husband
07/09	6	26	Home	Home	Childbirth delayed, husband
07/10	0	18	No previous birth	Hospital	Midwives, husband
07/11	4	27	Home	Home	Midwives, husband
07/12	4	33	Home	Hospital	Midwives, did preparations
07/13	0	18	No previous birth	Hospital	Friends, sister, midwives, husband
07/14	0	24	No previous birth	Hospital	Midwives, husband
07/15	0	22	No previous birth	Hospital	Midwives, did preparations
07/16	4	29	Home	Hospital	Previous childbirth difficult
07/17	4	22	Hospital	Hospital	Midwives, husband
07/18	0	18	No previous birth	Hospital	Midwives, husband,
07/19	1	20	Home	Hospital	Clinic, family, husband
07/20	0	20	No previous birth	Hospital	Midwives, husband, friend

All 11 participants who had a previous childbirth experience reported having adequate information on what to expect in childbirth. Eight of them said too that their last encounter giving birth influenced them to deliver in a hospital with this pregnancy. Only five participants who had a prior childbirth experience, however, reported using a hospital to give birth previously. Six participants delivered at home with their previous pregnancy. Participants 07 and 16 spoke of difficulties they experienced (delayed labor and profuse bleeding respectively) during their last childbirth experience at home that influenced them to now deliver in a hospital. Participant 16 explained, “I got baby at home and bleed and bleed, I blackout and everyone thought I was dead, so my husband said I shouldn’t take chance and get this baby at home.” Participant 11, however, shared a different perspective, “All my babies I got home, and there was no problem, so I plan to get this one too at home but wasn’t feeling well so came to the hospital for a checkup, and right away the nurses admit me for the baby.”

Theme 3: Fears and Concerns about Childbirth in Hospital

Respondents reported several fears and concerns about their childbirth experience. Twelve women highlighted matters related to their fear of dying during childbirth or experiencing complications and having no one to assist them in being a severe influence on them preferring to give birth in a hospital. Participant 7 explained, “I didn’t have a good pregnancy, so I fear getting baby at home in case I am not ok and something bad happens, I don’t want to die.” Other participants made similar statements. Many respondents stated that they had heard stories about the dangers of giving birth at home. Participant 16 stated, “I know someone who died at home, and now I fear getting baby at

home." All of the participants who had completed secondary school had heard stories about the dangers of giving birth in the absence of a midwife or a skilled attendant.

Another key concern expressed by participants about their experience of childbirth in a hospital is the overcrowding in the hospital with too few beds for the high patient load. Women highlighted this as significantly affecting their childbirth experience since many of them had to share beds with other women before and after labor. Participant 13 stated, "I share a bed with another woman who was in labor too, and it was difficult for me and her to be together as we were both feeling pain." Participant 12 seemed frustrated when she said, "This hospital hardly gets beds, and it is not ok to be with people in the same bed when you don't know them." Ten participants mentioned the congestion and overcrowding in the hospital as affecting their hospital stay. There was one discrepant observation with one participant who reported a positive experience sharing a bed as the woman with whom she shared the bed had many children and was able to assist her throughout her labor and childbirth experience.

Women also spoke of the hunger that they felt after giving birth in the hospital. They did not receive any water or food, and this was surprising for many of them. More than fifteen women spoke of feeling hungry and expressed concern about the lack of food from the hospital. Others mentioned the poor state of the hospital, lack of privacy, dirty toilets, ventilation and not enough midwives being available to provide service as primary concerns and fears. Participant 17 said, "I was hungry and want water to drink after I got the baby, but there was just no feeding for me." Participants 14 and 15 summed up their experience as "I was hungry and no food to eat."

Other fears and concerns expressed by women on their childbirth experience included lack of funds and fear that they would be asked to purchase drugs or other supplies at the hospital when they do not have any money. Some participants reported hearing other women being asked by midwives in the hospital to purchase medical supplies and drugs during their childbirth experience there. Additionally, other respondents highlighted their fear and anxiousness on who will take care of their children at home, not being happy with the birthing position that they were placed in to give birth at the hospital and the poor attitude of some of the midwives. These factors all contributed to women's reported negative experience of childbirth in the hospital. Participant 19 stated, "I don't like being on the bed with feet up on those things - by the bed, I want to squat but the nurse told me to go up on the bed and put my feet up, but that was not good." Participant 3 also stated, "It's not in my culture to come to the hospital to get baby, women always need to stay home and show their strength to hold up with pain."

Theme 4: Importance and Advantages of Childbirth in a Hospital

All 20 participants felt that it was vital for them to give birth in a hospital. The main reason highlighted by participants on the importance of childbirth in a hospital is the availability of qualified midwives, nurses, and doctors to provide care for them during emergencies or if they experience complications. Participant 16 stated, "I feel good getting my baby in the hospital because nurses and doctors there and know what to do if something goes bad." Similar statements were also expressed by participants 12, 15, and 18. Other women spoke of the availability of drugs and medical supplies in case they needed these during childbirth. Participant 6 who had initially planned to deliver at home

explained, “I fear something bad could happen to my babies but thank God the nurses were there at the hospital and know what to do.”

Twelve participants mentioned the importance of giving birth in a hospital as the care provided by nurses and midwives to their newborn babies. Other respondents explained that giving birth in the hospital also allowed the nurses and midwives to teach them to take care of their babies, to breastfeed, and provide vaccine for babies. Young participants, and those who were experiencing birth for the first time, particularly highlighted this. Participant 5 stated, “I was happy to get baby in the hospital because it help me register my baby easier.” Participant 18 also stated, “Nurse show me to breastfeed my baby, so I glad I got baby here.”

Theme 5: Individual Decision and Plan for Childbirth in Hospital

All participants except participant 6 expressed determination to give birth in a hospital if they were to be pregnant again. Participant 6 stated, “It is easier to get baby at home, so I would get my baby at home again if I feel ok during pregnancy.” Participants 5 and 8 were very assertive in their plans on where they will give birth if they become pregnant again. Participant 5 stated, “Even though the nurse was rude to me this time, I will go again to the hospital to give birth.” Participant 8 stated, “I am the one to decide where I get baby, so I know I will come back to the hospital if I get pregnant again.”

Participants also reported feeling satisfied and happy with their experience giving birth at the hospital, and this has enabled them to plan for future childbirth in a hospital. Some of the participants also reported that they would encourage their friends and family members to give birth in a hospital. Participant 10 stated that “Getting baby in hospital

was ok this time so I will come again to give birth.” Participant 10 explained, “I am happy with the care I got at hospital with my baby, so I will tell my friends to go to hospital to get their babies.”

Summary

I conducted a phenomenological study on women’s experiences using health facilities for childbirth in South Sudan. I conducted in-depth interviews with 20 women of various ages, ethnic tribes, and with different previous childbirth experiences. I reviewed the transcribed data with my field notes and also had it checked by a peer for data quality. I coded data by hand and then by computer using NVivo software. I stored data in a locked drawer and on password-protected disk.

I presented the demographic profile of the 20 participants. I outlined the findings under broad themes and subthemes, linking these to the questions in the interview protocol and critical elements of the HBM. I presented the results under five broad themes. The first related to the support, assistance, and advice received from family and friends particularly husband, mothers-in-law, and healthcare workers. The second theme related to information and people influencing the childbirth experience of women in the hospital. The next two thematic findings were regarding the childbirth experiences of women whether negative such as hunger and positive such as proper care provided by midwives. The final result was the plan and decision for future childbirth experience in a hospital that was positively expressed by many participants.

In the final chapter, I will discuss the findings from my research, explaining how this fits within the overall theoretical framework of the HBM. I will also analyze these

findings, making some conclusions based on the background and literature review. I will discuss the implications of these findings for practice and future research while making recommendations for future programs and policies to improve maternal health in South Sudan.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, I described the experiences of women using the Juba Teaching Hospital in South Sudan for childbirth. The use of health facilities for birth in South Sudan remains low, despite over 40% attendance rate at the antenatal clinic and 70% of the population reporting access to a health facility in the country (MoH & NBS, 2011; NBS, 2013). I used the HBM as the theoretical framework for this phenomenological study, with the goal of gaining a deeper understanding of this phenomenon.

In this final chapter, I will present a summary, reflections, and interpretations of the findings. I will analyze these findings based on the theoretical framework and literature review. I will discuss the project limitations and make some recommendations. I will then conclude with some discussions on the implications of these findings for practice and future research.

Summary of Findings

I analyzed these findings using five broad themes that were developed based on research questions, participants' response, and linkages to the theoretical framework.

The general statements were:

- The support, assistance, and advice women received during pregnancy and childbirth in the hospital.
- The information and people influencing birth in the hospital.
- The fears and concerns about birth in the hospital.
- The importance and advantages of birth in the hospital.

- The individual decision and plan for birth in the hospital.

The study revealed that there was an extensive network of support, assistance, and advice provided to women during pregnancy and childbirth. These networks included help from family members such as husbands and mothers-in-law, neighbors, and health care providers. There was a high attendance at the antenatal clinic by most participants where they were encouraged to come to the hospital for childbirth. Participants reported overcrowding, sharing a bed with other women, hunger, the poor state of the hospital, and lack of privacy as some of the factors affecting their childbirth experience in the hospital. Factors such as learning to care for their babies, care given to them in emergencies at the hospital, and the availability of drugs and supplies for treatment in the hospital were among some of the advantages reported by women on their childbirth experience in the hospital. I also found that most of the participants expressed a sincere desire to have future childbirth in the hospital and planned to encourage other family members and friends to give birth in a hospital.

Interpretation of the Findings

In answering my central research question on what are the experiences of women using health facilities for childbirth in South Sudan, I developed 25 open-ended questions in my interview protocol to respond to the four research subquestions. I then identified five broad themes and subthemes, based on the 25 open items in the interview protocol and the six elements of HBM. In interpreting these findings, therefore, I analyzed these themes and elements of HBM to answer my research subquestions.

RQ1: What are the Contexts and Situations That Influence Women to Decide and Use a Health Facility for Childbirth?

There were two broad themes identified that responded to this research subquestion. These were the support, assistance, and advice provided to women during pregnancy and childbirth in the hospital and the information and people influencing birth in a hospital. The study revealed that crucial family members, in particular husbands and mothers-in-law assisted women to decide and use health facilities for childbirth by encouraging them and accompanying them to health facilities for delivery. Neighbors also significantly supported women to go to the hospital to give birth by providing transportation in some cases, attending to their other children, and advising during pregnancy and childbirth. Previous studies have not included the specific roles of family members in facilitating childbirth experiences for women in health facilities. Some researchers, however, reported an association with the support from family and neighbors with women preferences for home deliveries (Exavery et al., 2014; Mason et al., 2015; Moudi et al., 2015) but none of these studies revealed any interconnections with giving birth in hospitals.

I also found that women utilized antenatal care services and the constant message and information received from health care providers during these visits also influenced them to use a health facility for childbirth. The study also revealed that early preparations for birth contributed to women going to health facilities for delivery. Participant 18 stated, “My husband help me pack a bag and kept some money, so it was easy for me to go to hospital.” Similar statements on making early preparations were also expressed by

participants 02, 04, and 13. Early birth preparation and hospital delivery is also not new information. Previous researchers highlighted the positive association between women's knowledge of birth preparedness and institutional deliveries (Brazier et al., 2014; Mason et al., 2015). None of these researchers, however, investigated the influences of thorough early birth preparations such as having transport monies available and making preparations for the care of other children by the women on their childbirth experience using the hospital. In this study, participants stated that making such detailed preparations before delivery provided a more positive experience for them as they did not have to worry about their other children at home while in the hospital.

RQ2: What are the Contexts and Situations That Prevent Women from Deciding and Using a Health Facility for Childbirth?

The fears and concerns women expressed about their childbirth experiences were consolidated under the broad theme identified to respond to this research subquestion. The study revealed that a significant fear among women was dying during childbirth or experiencing complications and having no qualified person to assist them. This finding confirms results from other studies done globally that show that perceptions and fear of complications during childbirth have significantly influenced many women's decision to go to facilities for delivery (Anyait et al., 2014; Kruk et al., 2014; Moudi et al., 2015). Anyait et al. (2014) found that knowledge of family members and friends having difficulties and dying during childbirth was a key factor for some women using health facilities for birth. Participants highlighted similar statements in this study. Participant 16

explained, “I know a friend who died getting baby, I fear death that’s why I come to hospital.”

This study also confirmed findings from previous studies that overcrowding, lack of privacy, and lack of transport are barriers for women’s use of health facilities for childbirth (Kawakatsu et al., 2014; Moudi et al., 2015; Wilunda et al., 2014). Participants highlighted the few numbers of beds at the hospital, sharing of beds by women, and no privacy as negatively affecting their childbirth experience in the hospital. Participants also highlighted concerns about the poor attitude of midwives, uncomfortable birthing positions, and expenses related to the purchase of drugs and supplies as potential obstacles to using health facilities for childbirth. Previous researchers noted similar findings (Abuya et al., 2014; Moudi et al., 2015; Wilunda et al., 2014).

The study revealed that hunger and lack of food also negatively impacted women’s experience giving birth at the hospital. Many women in the study reported feeling hungry and unhappy that they received no food or tea after giving birth at the hospital. This finding is specific to this study and has not been shown to be an inhibiting factor in previous studies reviewed. South Sudan is experiencing a severe economic crisis and food insecurity (IMF, 2017). This situation could be a contributing factor to the hunger and lack of food affecting women’s experiences at the hospital.

RQ3: How Have Women Described Their Experiences of Childbirth in Health Facilities in South Sudan?

In answering this research question, I analyzed information categorized under broad themes aligned to the importance and advantages of childbirth in the hospital and

some cross-cutting issues related to the fears and concerns women expressed about their childbirth experiences. Women reported on how comfortable they were with the hospital setting, the service they received from the midwife or health worker, and the care provided to their newborn babies. Women also responded to what they most and least enjoyed with regards to their childbirth experiences in the hospital. Participants described feelings of satisfaction with the care they received from healthcare providers for them and their babies. Women who faced complications during their current pregnancy reported not only feeling happy but also were thankful that they gave birth successfully.

The study further revealed that women described their experiences as learning. Some participants, mainly young respondents, reported that they learned to take care of their babies. Participants said gaining knowledge on how to bathe and feed their babies from health care providers and other more experienced women in the hospital was a positive experience for them. This learning experience reported by women is also contributing to new evidence, as previous studies did not show this as a finding. In general, even though this study revealed that some women shared terrible experiences related to poor attitude and uncomfortable birth positions, this did not alter their overall satisfaction with their childbirth experience at the hospital.

RQ4: What are the Reasons Women Give for Their Descriptions of These Experiences?

In answering this research subquestion, I analyzed responses women provided to questions in the interview protocol related to the reasons for their descriptions and what

plans or actions they will take based on their intentions. I analyzed this subquestion under the broad theme of individual decision and their plans for childbirth in the hospital. The study revealed that women were surprised by their experience and, therefore, described it positively. Most of the participants expressed low expectations of their childbirth experience in the hospital. This low expectation and voiced satisfaction have contributed to participants planning to give future births at the hospital if pregnant again.

The study revealed that participants were determined to give birth in hospitals in the future, even being prepared to defy family members if necessary to do so. Findings from the study show that participants were determined to give birth in hospital despite some negative experiences. One participant mentioned that the healthcare provider was rude to them, but she will still give birth at the hospital. The literature reviewed did not reveal similar findings. Previous studies found that mistreatment in the hospital was a barrier to future use of health facilities (Kawakatsu et al., 2014; Loke, Davies, & Li, 2015; Moudi et al., 2015). In this study, participants were committed to the future use of health facilities for childbirth.

Interpretations in the Context of the Theoretical Framework

I applied the HBM to describe women's experiences using health facilities for childbirth. The HBM has been used in previous studies to analyze behaviors and actions (D'Angelo, 2016; Loke et al., 2015; Jans, & Becker, 1984). In this study, I used the constructs of the HBM for analysis and interpretation of the information provided and shared by women on their childbirth experiences at Juba Teaching Hospital. Glanz et al. (2015) stated that the HBM is useful for analysis and explanations of decision making

and action on particular behavioral issues. I linked the six elements of the HBM: (a) perceived susceptibility, (b) severity, (c) benefits, (d) barriers, (e) prompts to action, and (f) self-efficacy to the five broad themes and four research subquestions. I applied all six elements of the HBM in my analysis and interpretation. No previous study in my review applied all six constructs of HBM to analyze use of health facilities for childbirth.

The application of the HBM constructs in this research confirmed findings from a previous study that found a significant association with crucial HBM elements and positive behavior and action (Loke et al., 2015). This study found that the HBM element relating to cues and prompts to act applicable as most participants in this study reported being encouraged to go to hospital for childbirth from the support, assistance, and advice they received from family members, neighbors, and health care providers. Similarly, HBM constructs relating to the perceived severity of consequences and perceived susceptibility were applied based on the sensed fear of dying expressed by many women in the study as influencing their actions to go to the hospital for childbirth. Previous studies also noted that perceived susceptibility and severity of consequences contributed to behavior change and effort leading to the use of health facilities (Mohtasham & Atefeh, 2013; Loke et al., 2015).

HBM constructs perceived barriers, and perceived benefits for action were also applicable to the fears and concerns women had and the advantages and importance of their childbirth experience in hospital respectively. I analyzed these elements in response to research subquestions identifying those contexts and situations preventing and influencing the use of health facilities for childbirth. Women in this study identified these

fears and concerns as barriers that could restrict their use of hospitals for delivery and the advantages as benefits that could influence their use of health facilities for birth. These findings are similar to other studies where the HBM was used to explain, predict, and analyze factors influencing and affecting the use of health services (Loke et al., 2015; Mohtasham & Atefeh, 2013; Moudi et al., 2015).

I also applied the final HBM construct of self-efficacy in this study. Glanz et al. (2015) described self-efficacy as individual empowerment to act. In this study, women were determined to return to health facilities to give birth which was as a result of their surprise and satisfaction with the services they received at the hospital. This belief that they could act regarding the use of health facilities for childbirth and their determination to tell others to give birth at the hospital was remarkable. It confirmed previous studies that show a significant correlation between self-efficacy and use of health services (Mohtasham & Atefeh, 2013; Jans, & Becker, 1984). I found in this study women's experiences using health facilities might have influenced their plan to give birth at the hospital.

Limitations of the Study

This study has several limitations. I conducted the research at the Juba Teaching Hospital in the capital city. South Sudan is a vast country with over 30 states and numerous counties with over 80% of the population living in rural areas. It is, therefore, not possible to generalize the findings from this study to all states and health facilities. I sought to include in the study, however, participants from many rural areas and communities within the country. This study is qualitative, using a small sample of

participants from eight ethnic tribes of the country. There are, however, over 40 different ethnic tribes, with various cultural practices and unique perspectives on the use of maternal health services (GOSS, 2011). The findings are, therefore, not applicable to all of the ethnic tribes and cultures in the country. In this regard, however, I sought to involve participants from some of the most important tribes in the country. Additionally, I conducted the study among women whom all experienced a positive birth outcome. This positive experience could have contributed to their positive outlook and description of their encounters giving birth in a hospital.

Recommendations

South Sudan is struggling to improve its maternal health indicators including increasing uptake of skilled attendance at birth and the number of institutional deliveries (MoH, 2014; MoH, 2017). As such, this research could help in the design of policies and programs to improve maternal health and reduce maternal mortality. I, therefore recommend dissemination of the findings from this research with key stakeholders including Government officials, hospital management, health care providers, and development partners so that they could use some of the evidence from this research to design programs and policies to improve maternal health services in the country.

The findings could also contribute to a greater understanding of actions to improve health and could provide valuable information for social change. I, therefore, recommend widespread dissemination of the results of this research. Stakeholders could include women and communities to generate their participation in programs to increase their use of health facilities, as well as mobilize support from their families to use health

facilities for childbirth. Such involvement could also contribute to real social change by ensuring more women access care at hospitals including when faced with complications during delivery.

Additionally, there is limited data available in South Sudan on the use of health facilities and maternity services in the country. This research will contribute some evidence on this critical issue. I, therefore recommend that there is further research to strengthen the evidence, to confirm and disprove some of the findings from this research. Other studies could be done to analyze this issue, using different theoretical models and possible quantitative studies. The application of new theoretical frameworks could also provide more information on this complex phenomenon. Further research is also recommended to consider more ethnic tribes and locations in the country for more generalization and comparison.

Implications

This study is unique as it is an under-researched area, relating to the experiences of women using health facilities for childbirth in South Sudan.

Positive Social Change

This research has the potential for creating real social change in the Republic of South Sudan. Essential elements of social change are mobilizing people's participation and taking transformative actions (Kristoff, & WuDunn, 2014). Increasing the uptake of women using health facilities for childbirth in South Sudan could make a significant difference in the lives of individuals, families, and communities but will require transformative action. Findings from my research could, therefore, contribute to

the development of innovative and robust policies and programs to improve women's experiences giving birth in health facilities and encourage more institutional deliveries in the country.

Theoretical and Empirical Research

This research will contribute to the body of evidence on maternal health care in general and in the use of health facilities in South Sudan. As highlighted, however, I conducted this study at the hospital in the capital. It would be significant, however, for more perspectives on women's experiences in villages since most of the population lives in rural areas. Further, all of the women in this study had positive birth outcomes that could have contributed to their positive experiences in the hospital. Research among women with adverse birth outcomes will also be necessary for analysis and comparison.

Maternal health services in South Sudan is very complicated, and I may not have answered all of the questions and addressed all of the issues relating to the use of health facilities for childbirth in this research. Other researchers and academia could, therefore, build on this research for more in-depth application of other theoretical frameworks on the use of maternal health services. They could also conduct other quantitative and qualitative studies to continue building this body of evidence on this complex phenomenon.

Policy and Practice

This research could provide the evidence for South Sudan to transform the provision of maternity services, influence community action, and family support to encourage women to use facilities for childbirth. Several key stakeholders in the country

could benefit from this research. These stakeholders include policymakers, government officials, and parliamentarians in the country, who are very concerned with the low use of maternity services and could use the results to develop innovative policies and programs. Development partners and United Nations agencies could also use the findings to strengthen technical assistance and programming on maternal health. Health service managers, program implementers, and health care workers including midwives could also use this research to enhance program delivery and strengthen initiatives to increase utilization of maternity services at health facilities.

Conclusion

Strategies to increase the use of health facilities for childbirth could contribute to improving health outcomes for mothers and newborns in South Sudan. It is a priority of the Government (MoH, 2017) to increase institutional deliveries. I conclude from the findings of this study, that women could be influenced and prompted to use health facilities for childbirth by their family members especially mothers-in-law and husbands. Further, there is evidence that having food or tea, providing privacy, teaching women to care for their babies after birth, giving respectful and culturally sensitive care to women in the hospital could improve their childbirth experiences and possibly increase their use of maternity services. This research involved people and women, which is essential as real social change is participatory and transformative (Kristoff, & WuDunn, 2014). The findings and conclusions from this research could, therefore, enhance programs in hospitals and health centers to improve women's experiences using health facilities for

childbirth. Additionally, an improved understanding of this social dilemma could empower and transform maternal health services in South Sudan.

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Appendix A: Confidentiality Agreement

Name of Signer:

During the course of my activity in collecting data and transcribing data for this research: Women's Experiences Using Health Facilities for Childbirth, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Appendix B: Letter of Cooperation

Ministries Complex

Dear Gillian Garnett,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Women's Experiences Using Health Facilities for Childbirth in South Sudan within the Juba Teaching Hospital. As part of this study, I authorize you to recruit participants for your study, collect data by conducting interviews with participants and make any arrangements to share the findings of your research once completed. Individuals' participation will be voluntary and at their discretion.

We understand that our organization's responsibilities include: allowing the use of the maternity unit ward for you as a researcher and any assistant that you have to recruit and interview participants for your research. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University Institutional Review Board.

Sincerely,

Chairperson of Medical Research Board
Ministry of Health

Appendix C: Interview Protocol

Time of Interview: _____________________________________
Date: _____________________________________
Place: ______________________________________
Interviewer: ______________________________________
Interviewee: ______________________________________

A. **Opening** (use complete introduction if being done sometime after consent form signed)

I would like to introduce myself again. I am Gillian Garnett, a doctoral student in Public Health at the Walden University. Thank you for consenting to participate in this interview. As I mentioned when you completed the consent form, this research is part of my doctoral studies, which I am conducting in Juba County in the newly created Jubek State. This research focuses on women's experiences using health facilities for childbirth. I would also like to remind you that you can decline to answer any question. It will not affect any of the services that you will receive, or you will not be penalized for the information that you provide. The findings from this research could help in improving services for other women coming to hospitals to give birth including yourself if you are going to get a next child. This interview will take about 60 minutes. If at any time you feel tired or would like to stop the interview, please let me know, and we could stop and continue the next time at your convenience. I would not share any of the information that you give. It will be kept confidential, and your name will not be used in the research report. I will also be using a voice recorder so that I could correctly capture all the information that you provide. I will now begin this interview.

B. **Background:**

1. Tell me about yourself? Further probe if not provided: How old are you? Where were you born? Where do you live? How many children you have? What is your marital status? What ethnic tribe do you belong to? Are you working? Did you complete primary and secondary school?
2. Tell me about your family? Further probe if not provided: Do you have parents, brothers, and sisters? Are any of them living with you in the same house? Do you see them often? What is your relationship like with your family? What advice or help would any of your family members give to you? Do you take this advice or help? What are the reasons for your answer? Would any of your family members give advice and help on issues related to pregnancy and childbirth? Which one of your family member? What kind of advice and help related to this would he/ she/ they give?

3. Tell me about your community? Further probe if not provided: How would you describe your community? What are your reasons for describing your community in this way? What is your relationship like with your community in general? What advice or help would you get from community members? Who in particular in the community would give advice and assistance? Do you take this advice or help? Would your community give advice and help on issues related to pregnancy and childbirth? What kind of advice and help related to this would they give?

(Note: If this is the first time to give birth, skip question 4)

4. Tell me about your previous experience giving birth? Further probe if not provided: How old were you? Where did you give birth? What made you decide on the place of birth? What was the experience like? Describe what you could remember about your feelings at that time? Tell me how you think that your experience then is related to your decision now to give birth at a health facility (if any)?

(Explain to the participant that you will now discuss your recent childbirth experience)

C. Preparing to give birth

5. Tell me about your experience with this pregnancy? Further probe if not provided: What was your health like during this pregnancy? What were your feelings about the pregnancy? What supports and from whom did you get while you were pregnant?
6. Tell me about your experience with antenatal care? Did you go to the antenatal clinic? Where did you go? What were your feelings about the clinic? What did you discuss related to giving birth? What are your feelings about the health workers who attended to you while attending the antenatal clinic? How would you describe the experience of getting antenatal care? Did the antenatal care you receive relate in any way with your decision to go to a health facility for childbirth? What are the reasons for your answer?
7. Tell me about any preparations that you made before with regards to the current birth of your child? Further probe if not provided: What preparations did you make before your child was delivered? Who helped you (if anyone) with these preparations?

D. Deciding on giving birth at a health facility

8. Tell me about the time when you started experiencing labor pains? Further probe if not provided: When did it start? Where were you? What were you doing? Who

were you with (if anybody)? What did you do? What were your feelings at that time?

9. Tell me about the decision to go to the health facility? Further probe if not provided: How did you decide to go to the facility? Who helped you make that decision? How long did it take for you to decide to go to the health facility to give birth?
10. Tell me more about the general situation related to your decision to give birth at a health facility? Further probe if not provided: What would you say helped you or your family with the decision to go to the health facility for you to give birth? What factors would you say could have prevented you from deciding to go to the facility for childbirth?

E. Arrival at a health facility to give birth

11. Tell me about the experience getting to the health facility to give birth? Further probe if not provided: How did you get to the facility? Who helped you? What other factors contributed to you reaching the health facility? What factors could have prevented you from reaching the facility? What were your feelings on the way to the health facility?
12. Tell me about your experience on arrival at the health facility? Further probe if not provided: Whom did you meet at the health facility? What did they say to you? How would you describe the attitude of the health worker whom you met on arrival at the health facility? Describe your feelings on arrival at the Health facility?

F. Experiences giving birth at the health facility

13. Tell me about the health facility itself? Further probe if not provided: How would you describe the rooms where you were and where you delivered your baby? How comfortable were you with the rooms, bed and other facilities?
14. Tell me about your experience while in the facility waiting to give birth? Further probe if not provided: describe your feelings during this time? What support did you get from health workers at the facility? Did you feel that it helped? Did you get any other support?
15. Tell me about other women you met at the health facility waiting to give birth? Further probe if not provided: What were your interactions like with any other women you met at the health facility?
16. Tell me what you remember about your experience giving birth? Further probe if not provided: What happened? Who delivered you? How would you describe the experience? Were you comfortable with the position in which you delivered?

Were there any special requests that you made with regards to your delivery? Were these granted? Tell me more about your feelings at that time? How would you describe the skills of the midwife or health worker who attended to you?

G. Experiences after giving birth at the health facility

17. Tell me what happened after you delivered your baby? Further probe if not provided: Describe your feelings after the birth of your baby? What support did you receive after the birth of the baby and from whom? How would you describe your experience at the health facility where you deliver (what words would you use or say)?
18. Tell me about your newborn baby? Further probe if not provided: What baby did you get? How is your baby? How would you describe the care given to your baby?
19. Tell me about your experience when you were ready to leave the hospital? Further probe if not provided: What happened? Who assisted you? Who came to collect you? What were your feelings about how prepared you were with regards to taking care of your baby? How would you describe this experience?
20. Tell me what you enjoyed most about going to this health facility to give birth?
21. Tell me about what you enjoyed least about going to this health facility to give birth?
22. Tell me about whether you will come again or tell anyone to come to this health facility to give birth if they are pregnant? Tell me the reasons for your answer
23. Explain what was important for you to give birth at a health facility?
24. Describe your feelings about going back to a health facility to give birth?
25. Tell me about any support that you received from family, friends or community after the birth of your baby?

H. Conclusion

This brings us to the end of the interview. I know it was long and I would like to express sincere thank you for your participation in this research. I will transcribe the information on the recording, and in case I needed to clarify any answer that you provide, I would like to contact you again on this. Please let me know if I can do this and if I can do this by telephone or other means. This information will be put together with the other interviews that I will collect, and I will do a report and submit to the university. Please do remember if you have any questions, later on, you can contact me on telephone number +211955649120 or by email at gillian.garnett@waldenu.edu. This information is also in the copy of the consent form that I have given to you earlier. Thank you again for participating in the interview.