ORIGINAL RESEARCH

Childbirth in South Sudan: Preferences, practice and perceptions in the Kapoetas

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BACKGROUND: Focus group discussions (FGDs) were designed to better understand the community's views and preferences around maternity care to design a communications campaign to increase facility deliveries and skilled attendance at birth in the three county catchment areas of Kapoeta Civil Hospital.

METHODS: Twelve FGDs were conducted in Kapoeta South, Kapoeta East, and Kapoeta North counties. Four South Sudanese facilitators (two women, two men) were hired and trained to conduct sex-segregated FGDs. Each had 8-10 participants. Participants were adult women of reproductive age (18-49 years) and adult men (18+ years) married to women of reproductive age.

RESULTS: The majority of participants' most recent births took place at home, though most reportedly intended to give birth in a health facility and overwhelmingly desire a facility birth next time. Husbands and the couple's mothers are the primary decision-makers about where a woman delivers. More men than women preferred home births, and they tend to have more negative opinions than women about health facility deliveries. Though participants acknowledge that health facilities can theoretically provide better care than home births, fear of surgical interventions, lack of privacy, and perceived poor quality of care remain barriers to facility deliveries.

RECOMMENDATIONS: Interventions encouraging facility births should target the decision-makers—husbands and a couple's mothers. Improvements in quality of care are needed in health facilities. Developing social network interventions that circulate positive experiences about delivering in health facilities may be effective in changing public perception and decision-making about facility deliveries. Additional research and pilot testing is needed to more fully inform effective social and behavioural change strategies around maternal health in the Kapoetas in South Sudan.

Keywords: *Maternal health, childbirth, facility deliveries, behaviour change, qualitative*

Introduction

In July 2014, the American Refugee Committee (ARC) was awarded a grant from the Health Pooled Fund to improve the capacity of Kapoeta Civil Hospital to provide comprehensive emergency obstetric and neonatal care (CEmONC) in order to reduce maternal and neonatal mortality. This project focused on improving the facility infrastructure and human resource capacity to provide all nine signal functions of CEmONC. Another component of this project was to increase community awareness and demand for emergency obstetric care.

In 2015, the average health facility delivery rates in Kapoeta Civil Hospital's catchment area were low: Kapoeta South (8.8%), Kapoeta East (2.3%), and Kapoeta North (2.2%) [1]. There is shortage of human resources for health in South Sudan. Kapoeta Civil Hospital is one of the few facilities in the three-county catchment area that has skilled birth attendants: midwives, nurses, and doctors who have undergone formal training. Traditional birth attendants (TBAs) often assist home deliveries, but they do not have formal training and are unable to handle complicated deliveries.

These focus group discussions (FGDs) were designed to better understand the community's views and preferences around maternity care to design a communications campaign to increase facility deliveries and skilled attendance at birth.

Methods

An exploratory, qualitative study was conducted using principles of grounded theory [2]. Twelve FGDs were conducted September 4-6, 2014 in Kapoeta South, Kapoeta East, and Kapoeta North counties in both urban and rural areas. Four South Sudanese facilitators (two women, two men) were hired and trained to conduct the FGDs. FGDs were sex-segregated and conducted in Toposa or Juba Arabic, with direct translation into English. Each had 10 participants and lasted 60-90 minutes.

Adult women of reproductive age (18-49 years) and adult men (18+ years) married to women of reproductive age were recruited to participate. Participants were selected based on maximum variation of age, socioeconomic status, and delivery experiences (location, type of birth assistant). Participants all chose to participate willingly and provided verbal consent. Soda and biscuits were offered to participants; no other gifts or incentives were provided.

Facilitators used a discussion guide; they were encouraged to probe and explore issues as they emerged. Participants were asked about their perceptions of available antenatal and delivery services, pregnancy care and delivery experiences both at home or in health facilities, birth preparedness and emergency preparedness practices, spheres of influence and decision-making for deliveries, and related topics.

Thematic analysis was conducted based on facilitators' notes and a debriefing session with facilitators. Analysis explored systematic variations in responses by sex and FGD location (urban/rural); differences where noted are reported. Results were verified and refined with community members and stakeholders. Responses are qualitatively categorized in the results to summarize their relative weight. "Most" or "majority" suggests approximately 75% or more participants responded similarly; "many" refers to greater than 50% but less than the majority; "few" refers to approximately 25% or less. Outliers were fully explored and reported where authors determined they highlighted unique and important perspectives.

Results

A total of 120 people (60 male, 60 female) participated. Participant characteristics are summarized in Table 1.

Delivery location

The majority of women and men both responded that their (wives') last birth took place at home. Nevertheless, all but one woman and several men said they would have preferred to give birth in a health facility, but labour caught them off guard or delivery happened "abruptly". Most women indicated they viewed the health centre as a place to go in case of emergency, not necessarily for routine deliveries.

Women that gave birth at a health centre generally had positive opinions of the facility. In contrast, most men had negative opinions of facility delivery services (both perceived and based on actual experience). They commented the facilities are not up to required standards and cited drunk health care workers; nurses demanding money (government health care services are supposed to be free); midwives holding a grudge against the husband and thus either mistreating his wife or killing their baby; doctors exchanging people's children; and the umbilical cord being thrown in a latrine, which causes newborn death or difficulties conceiving in the future (traditionally, umbilical cords are buried under a special tree).

If participants had a complaint about the care they or their wives received during labour, most said their course of action would be to change delivery locations next time. Few said they would provide direct feedback to the facility in-charge or to the midwife.

Both men and women expressed serious concerns about privacy, particularly at the health facility. Women reported fears of male nurses assisting them during labour; they wished to be alone with a female midwife. One man also said the prospect of health facility workers "looking directly at her private parts" made him uncomfortable.

Nevertheless, both female and male participants overwhelmingly reported wanting to give birth in a health facility for their (wives') next birth. They explained health facilities offer better services, skilled personnel, and drugs and vaccines. On the other hand, they have seen women suffer and die in home births due to the unclean environment and TBAs' lack of training.

Influence on decisions about delivery location

In deciding where to give birth, women most often said their mothers/mothers-in-law made the decision; others mentioned husband, sister, and midwife. Equal proportions of men reported they themselves, as husbands, and their mothers/mothers-in-law make this decision. Notably, no participants mentioned the pregnant woman has any input or decision-making influence about where she gives birth.

Both men and women overwhelmingly reported the husband makes the decision about when to seek care if

Table 1. Participant characteristics by location (numbers).

	Male		Female		TOTAL
	Urban	Rural	Urban	Rural	
Kapoeta South	10	10	10	10	40
Kapoeta East	10	10	10	10	40
Kapoeta North	10	10	10	10	40
Total	**60**		**60**		**120**

his wife experiences complications. Men explained a belief that if a woman experiences obstructed labour it means her baby was conceived with another man. Before the husband allows his wife to be transported to the hospital, he must find the man that impregnated his wife and oblige him to offer an animal sacrifice. Such traditional practices may contribute to the delays in seeking skilled birth services.

Birth attendant preferences

Both men and women reported wanting their birth attendants to give respectful, kind, patient-centred care, including maintaining privacy in the delivery room, not hurrying them during labour, and respecting preferred delivery positions.

Most women and men said they preferred midwives to assist them in their (wives') delivery, because they are well-trained and knowledgeable, provide good care and treatment, have respectful manners, and give gifts following delivery (mosquito net, soap, towel). Men insisted that midwives and nurses pursue continuing medical education to ensure current knowledge, ethics, and professionalism. A few respondents preferred TBAs

Table 2. Recommendations to address barriers to facility deliveries

Barriers to Facility Deliveries	Intervention Recommendations
Women are caught off guard at the onset of labour and give birth before transportation can be arranged.	Build on existing birth planning habits. For example, couples already save money in case of an emergency—encourage them to go one step further by identifying emergency transport options and saving emergency numbers.
Men, and the couples' mothers are the primary decision-makers about where a woman delivers. More men than women prefer home births and have negative opinions about delivering at health facilities.	Interventions must target the decision-makers. They should also include the expectant mother to empower her to have a voice in the decision-making process. Conduct additional research with couples' mothers. Their insights may be critical in understanding the decision-making process about delivery location and/or choice of birth attendant.
Women view health facilities as a place for emergencies, not necessarily for routine deliveries. Fear of surgical interventions which are believed to limit future fertility.	Outreach and education via home health promoters.
Lack of privacy	Implement improvements in health facilities to meet the privacy expectations of women and their partners.
Traditional practices: - Inability to conduct traditional practices with the umbilical cord. - Beliefs about origins of complications and traditional practices to resolve them that delay transfer to facility.	- Facilitate brainstorming sessions between community members and clinicians to find innovative solutions that respect both traditional practices and medical infection prevention protocols. - Work with community leaders to change social norms to prioritize emergency transfers for women and resolve social issues later.
Perceived and experienced poor quality of care at the health facility. Lack of knowledge/empowerment to provide direct feedback to the health facility.	Implement quality improvements in health facilities. Develop community feedback mechanisms, e.g., through Boma Health Committees. Capitalize on trust in and perceived support from midwives to change public perception about quality of care at health facilities.
Fear of the unknown: As facility delivery rates in this area are so low, there are very few experiences—positive or negative—to be shared among community members. Social network research has shown how social networks can serve to effectively circulate and reinforce fears, misperceptions, and misinformation [3,4].	Demystify the facility birth experience. Develop social network interventions that circulate positive experiences delivering in health facilities.

due to their experience and good care assisting many deliveries in the village.

When asked who made them feel most confident or hopeful during delivery, women cited midwives and TBAs in equal proportions. For both, women mentioned feeling respected, well cared for, and supported. Nevertheless, when asked if a caregiver ever became frustrated with them during labour, the majority of women said yes. In all but one example, it was the TBA that got frustrated, made the woman feel cowardly, and left her to deliver alone. Only one woman reported that a health facility worker got frustrated with her. In this instance, a midwife slapped her during delivery because she refused to give birth from a bed, which made her lose energy to push and eventually required a Caesarean section.

Complication readiness

Both men and women cited complications (haemorrhage, long labour, and umbilical cord complications) as the greatest fear in delivery. Participants were particularly concerned about surgical intervention (episiotomy, Caesarean section), as there is a belief it will impact future fertility. Women also expressed fears about neonatal death and, less often, maternal death during delivery.

To prepare for emergencies, women and men frequently said they set aside money for treatment or transport. Nevertheless, transportation issues were the most commonly cited barrier to reaching a health facility in the case of an emergency. Additionally, two men said they got the doctor's contact information in case of emergency.

Discussion

The majority of participants' most recent births took place at home, though most reportedly had intended to give birth in a health facility and overwhelmingly desire a facility birth next time. Additionally, participants strongly prefer midwives as births attendants; a skilled provider is only available in a health facility. What might explain the disparity between intention/preference and actual practice?

Though participants acknowledge that health facilities can theoretically provide better care than home births, a number of concerns seem to present barriers. Participants notably did *not* mention finances as a barrier. Suggestions for addressing the barriers are summarized in Table 2.

These barriers and recommendations are not exhaustive. As this was an initial, exploratory study, additional qualitative research would be useful to deepen the understanding of the issues that emerged and more fully inform effective social and behavioural change strategies. A population-based quantitative study designed around these finding would be useful to quantify the themes and therefore assist in prioritizing interventions that are likely to have the greatest impact.

Limitations

The quality and depth of the data collected may have been compromised by facilitators' relative inexperience. Though a seasoned ARC qualitative researcher trained the most qualified facilitators we could identify, these were the first FGDs the facilitators had ever conducted. Experienced South Sudanese researchers are scarce.

Social desirability bias may be a possible explanation for participants' paradoxical preferred versus actual delivery location. Participants could have stated a preference for facility delivery for their (wives') next birth so as to be seen by their peers or the facilitators as "knowledgeable" or "modern". However, care was taken to design questions that were not leading, and FGDs were conducted away from health facilities and not in the presence of health workers.

References

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