AN INVESTIGATION INTO THE RIGHTS OF WOMEN TO MATERNAL HEALTH

A CASE STUDY OF JUBA COUNTY

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Dedication

I dedicate this research work to my wife, my parents, relatives and friends who have supported me throughout my studies.

Acknowledgements

For having completed this work, Glory goes to God the almighty. I extend my gratitude to my supervisor Dr. Margaret Angucia for the remarkable and consistent guidance and support accorded to me to enable accomplishment of this work.

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List of Abbreviation

WHO	:	World Health Organization
UMU	:	Uganda Martyrs' University
ANC	:	Antenatal Care
S.D	**:**	Standard Deviation
HIV	:	Human Immune Deficiency Virus
PHCC	:	Primary Health Care Center
SPSS	:	Statisical Package for Social Sciences
CBO	:	Community Based Organizations
CEDAW	:	Convention on the Elimination of Discrimination Against Women

Abstract

This study was set to investigate the rights of women to maternal health in Juba County, South Sudan. Its objectives were to find out the level of knowledge about maternal health rights, establish the extent to which the pregnant women were accorded maternal health rights by the health workers and ascertain the factors inhibiting compliance with maternal health rights of the pregnant women.

The study utilized a cross-sectional study design that was both quantitative and qualitative in nature. The data was collected from 175 pregnant women who were attending ANC and 10 health workers in 10 selected health facilities located in Juba County. The study found that most pregnant women had a high level of knowledge about their right to healthcare before, during and after pregnancy and childbirth (46.9%) but generally had low level of knowledge about maternal health rights (Mean = 2.92, S.D = 1.26). It also found that much as most pregnant women often accessed healthcare whenever they visited the health facilities as a maternal health right (35.3%), there was a low accordance of maternal health rights to them by health workers (Mean = 2.91, S.D = 1.28). The study found a few qualified health staff (4.9%), improper legislation supporting health care services (21.8%) and insecurity (29.7%) as the factors borne of government that inhibited the health staff from according the pregnant women maternal health rights while cultural beliefs (21.2%), long distances (100.0%), lack of transport (57.6%) and restriction by their husbands (51.5%) as the factors borne of pregnant women or their spouses that inhibited pregnant women from receiving maternal health care.

It was concluded amongst others that there is generally less knowledge on part of the mothers in as far as the maternal rights are concerned attributed to less education and low sensitization among the population.

The study recommended among others the need to increase advocacy in as far as maternal health rights were concerned but targeting the women of reproductive age and that maternal health rights should be integrated with the cultural beliefs for coherence with known cultural practices borne of the community to improve maternal health rights accordance.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

This study is an investigation into the rights of women to maternal health, a case of Juba County. The maternal health rights of women attending ANC in Juba County health facilities is conceived in this study as the independent variable, while maternal health is the dependent variable. This chapter presents the background to the study, the statement of the problem, objectives of the study, research questions, scope of the study, significance of the study, justification and operational definition of terms and concepts.

1.1 Background to the study

The term maternal health refers to the health of the woman right from pregnancy, childbirth and postpartum period (World Health Organization, 2013). Its importance is embedded in ensuring that women as a community foundation participate in efforts that are geared towards impacting positively in a community.

According to United Nations Human rights Commission human rights are entitlements inherent in every human being regardless of sex, nationality ethnic origin, color etc

Human rights are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. It is also acceptable that affirming to such reproductive rights of women like enabling access to skilled birth attendance, emergency obstetric care, contraception, safe abortion services and comprehensive post-abortion care are key to ensuring maternal deaths are prevented (Freedman, 2001).

Despite such importance it remains unfortunate that on the global scene up to 20 million females both girls and women suffer from maternal morbidities annually (Women Deliver, 2010). Besides an estimated 536,000 girls and women die from pregnancy related causes (World Health Organization, 2007). What is much more unfortunate is that the developing countries are characterized as a home to more than 99% of these maternal deaths occurring globally (United Nations Children's Fund, 2008). The young women experience problems during pregnancy and delivery due to incomplete body growth let alone obstructed labor (Bearingeret al., 2007).

In Africa, child bearing remains the leading cause of death among the women aged 15 to 19 years. The situation is much worse in the sub Saharan Africa where women of reproductive age are at a much high risk of dying while giving birth globally (United Nations Children's Fund, 2008). In the same Sub Saharan Africa it is estimated that up to 1000 women die per 100,000 live births which is far higher than the24 deaths per 100,000 live births within European countries (World Health Organization, 2005).

In another development the research done by the PMNCH (2015) stated that preventable maternal death, child mortality and morbidity remain high in many countries, and reflect deep inequities within and across population groups Systematic integration of international human rights standards and principles in laws, policies and programmes contributes to women's and Children's health and wellbeing. Almost all maternal deaths are avoidable, maternal mortality is also an issue of human rights (Ratsma and Malongo 2009). Here the scholars described indicators to monitor and evaluate the strategy and suggests how transparency through sharing information and accountability should be ensured if knowledge about the rights to maternal health of women are ensured. Practical guidance is now available to assist countries in doing this so this research was intended to

compare with the maternal health situation in Juba County where this research was conducted to assist the policy framework in getting the much needed help for the new country. This knowledge introduces the importance and added value of human rights standards and principles, and provides practical examples of human rights integration for women's, rights to maternal health along the life course, and across the policy cycle and in service delivery.

It is however known that effective adherence to the rights of women in relation to maternal health serves as an impetus in averting such maternal morbidities and mortalities amongst the women of reproductive age (Ratsma and Malongo, 2009).

In South Sudan however maternal ill-health remains one of the public health challenges that the country faces even in the light of the government ratifying the maternal health rights of women during pregnancy, at birth and during the post-partum period (Nada, 2011). The country is characterized by 2,054 maternal deaths per 100,000 live births, the highest maternal mortality rate ever in the world with each mother having one in seven chance of dying in childbirth during her lifetime (Mugoet al., 2015). Much as the government is supposed to carry out its obligation in provision of pregnancy related care, the dignity and rights of women to maternal health remains in balance (IIMMHR, 2010).It is against this background that this study investigates the rights of women to Maternal Health with evidence from Juba County, South Sudan.

1.2 Problem statement

In South Sudan maternal ill-health remains one of the public health challenges that the country faces. It is acknowledged that only 26.2% of women in South Sudan had access to antenatal care services by skilled health personnel as of 2006 which increased to 40.3% in 2010(MoH & National Bureau of Statistics, 2013). This implies that up to 59.7% of the

women within the reproductive age bracket go without access yet it is a maternal health right. Besides, the maternal health utilization services in South Sudan indicate that the birth attended by skilled personnel is at 17% leaving out the majority 83% of the total population nationwide (WHO, 2012). Such inaccessibility to maternal health care services is attributed to failure for the country health care system to accord maternal health rights to the women during pregnancy, child birth and the post-partum period.

The government has effortlessly put in place infrastructure to ensure maternal health care services to the women but feasible results remain to be seen. Without proper redress, limited maternal health care access will be consequential in the successful building of healthy families and societies for better health systems and healthy country growth. South Sudan maternal deaths are the result of inequities where other places are very poor and other social conditions including poverty, harmful gender practice where women handle most domestic work, ethnic and violence, lack of access to quality education, malnutrition and disadvantaged geographical location (WHO, 2012). Meaning the rights of women to maternal health has not been taken as a serious issue in the policy of the government.

It is also important to note that the government of South Sudan's efforts to ensure and improve both access to, and quality of care are hindered by the failure to eradicate discrimination, violence and social exclusion in policy development and service provision. Most of the institutions in South Sudan have too few women who are able to participate meaningfully or even to have their interests represented in the development, implementation and evaluation of laws, policies, programmes and services that affect their health and wellbeing much as the transitional constitution provides for 25% of women participation in all institutional development and have the rights to compete with men for the 75% of the remaining space in the element of development in the nation. The above is

aclear evidence that there is a research gap related to the rights of women that should have been implemented to bridge the problems affecting women.

This study thus investigates the rights of women to Maternal Health with evidence from Juba County within South Sudan as to come up with appropriate intervention for optimal redress.

1.3 Objective of the study

1.3.1 Major objective

To investigate into the rights of women to maternal health with evidence from Juba County, South Sudan

1.3.2 Specific objectives

1. To investigate the level of knowledge on maternal health rights among pregnant women attending ANC in Juba county

2. To investigate the extent to which health workers' comply with maternal health rights of the pregnant women attending ANC in Juba County health facilities

3. To investigate the factors inhibiting compliance into the rights to maternal health of the pregnant women in Juba County Health facilities

1.4 Research questions

i. What is the level of knowledge about maternal health rights among pregnant women attending ANC in Juba County health facilities?

ii. To what extent have the health workers' accorded maternal health rights to the pregnant women attending ANC in Juba County health facilities?

iii. What factors inhibit compliance with maternal health rights of the pregnant women among ANC health care staff in Juba County health facilities?

1.5 Scope of the study

1.5.1 Content scope:

The study provides an investigation on the rights of women to maternal health**.** It particularly limits itself to finding out the level of knowledge about maternal health rights among pregnant women attending ANC, establishing the extent to which health workers' comply with maternal health rights of the pregnant women attending ANC and ascertaining the factors inhibiting compliance with maternal health rights of the pregnant women among ANC health care staff.

1.5.2 Time scope:

The study limited itself to findings on rights of women to maternal health from the early 2012 to 2016. This time period is chosen because it represents the time between when South Sudan got independence and dynamic ratification of the rights of the citizens in which maternal health rights are part.

1.5.3 Geographical scope:

The study was carried in Juba County, the largest county in South Sudan. This areas is located in Central Equatoria state and serves both as the capital of Central Equatoria state and capital city of South Sudan. Juba County is chosen because of its accessibility to the various locations within the County**.**

1.6 Significance of the study

To the different stakeholders the results of this study were of importance in the following elaborated ways;

The study results were meant to enable the government through its policy makers to design and institute appropriate policies that support the maternal health rights in recognition of their importance.

To the health facility management, the results of this study would enable management of health facilities to design appropriate informed strategies on how to help the women within the reproductive age be accorded maternal health rights.

To the scholars, the results of this study were meant not only to form a basis for further research but also add to the bank of knowledge with regard to the rights of the women about maternal health.

Lastly the successful completion of this study was meant to enable the researcher to partially meet the requirements for the award of a degree of Masters of Arts in Local Governance and Human Rights.

1.7 Justification of the study

The study of the women's rights to maternal health is important because it will enlighten the readers about the importance of the right of mothers to maternal health. The issue of maternal death as indicated in the background is so alarming in South Sudan and Juba County is not exceptional. This study attributed the cause of maternal death to lack of information on the elements of rights to maternal health. Also there no clear policy guide to inform women about their rights to maternal health therefore this study through its investigation into the level of knowledge, investigation into level of accordance and factors inhibiting compliance will shade as a guide that will be important to get some insight to maternal health rights of the women in Juba County.

There are no feasible empirical studies that involve maternal health rights in South Sudan and in particular Juba County. Besides none of the studies have made use of both qualitative and quantitative approaches which this study adopted justifying the current study undertaking.

1.8 Definition of key terms

Health: According to WHO health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

Maternal health: This term is used to refer to the health of a woman from pregnancy, childbirth and postpartum period

Human Rights: Human rights are basic fundamental rights and freedom that belong to every person worldwide for being human.

Women: According to free English dictionary, women are female person distinguished from a girl or a man.

Reproductive age: This is defined as age of women 15 to 45 years

Maternal health Rights: Since maternal health is defined as the health of woman from pregnancy, child birth and postpartum period, Maternal health rights then is the entitled to for being a woman during pregnancy, childbirth and postpartum period.

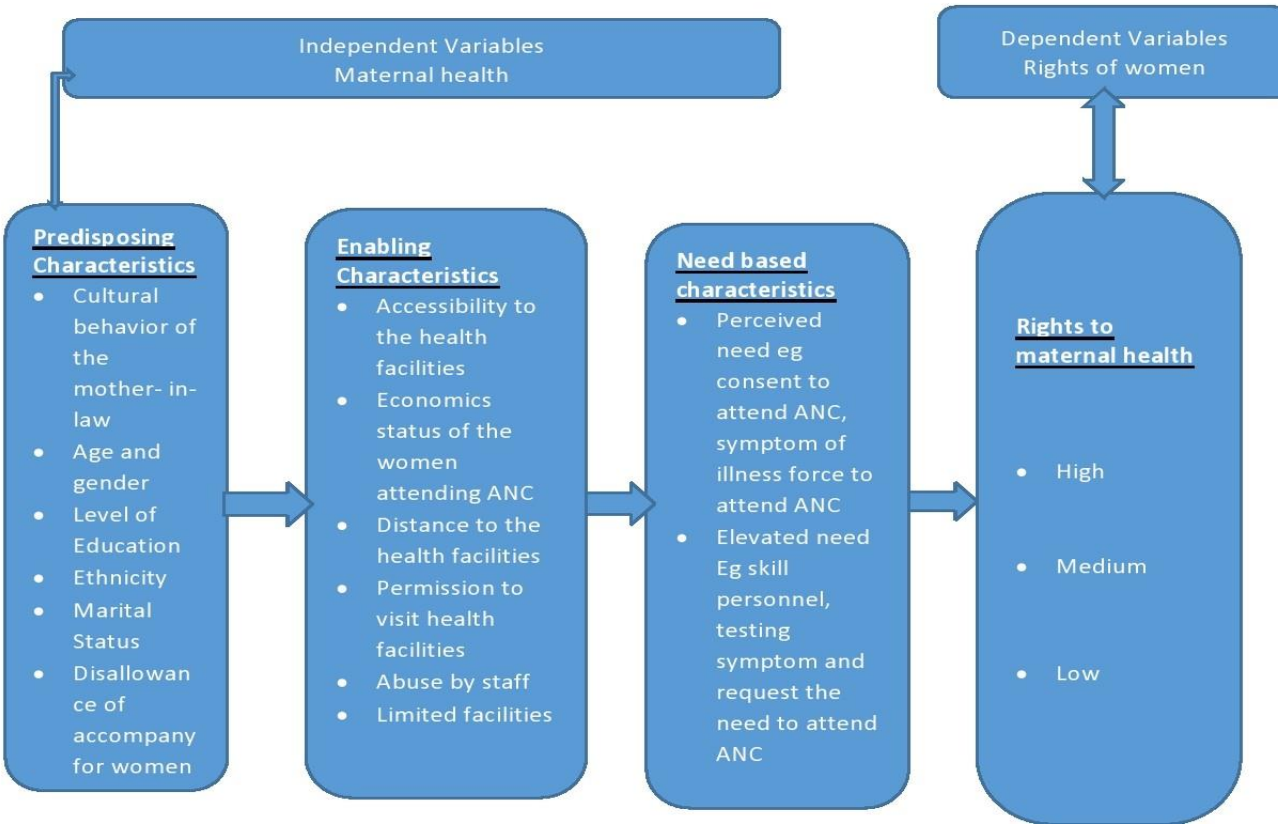
CHAPTER TWO:

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

According to Miles and Hubberman (1994) conceptual framework is the concept, assumptions, expectation, belief and theories that supports and inform your study. Miles and Hubberman (1994) further regarded conceptual framework as a visual or written product that explain either graphically or in form of narrative that form the key factors and characteristics of the problem being studied. Conceptual framework of the study shows how this study was derived from. This framework acted as aninformation directive for this research on the rights of women to maternal health. The conceptual framework of the study is prepared based on Anderson's behavioral model of the determinants of maternal health service utilization linking it to the benefits of the maternal health rights for the pregnant women. Anderson grouped the independent variables to include the predisposing factors, enabling factors and need factors while dependent variables to include level of utilization of the maternal health services as demonstrated in the below diagram

Figure 1 Conceptual framework of the study. This is adapted from Andersen behavioral theory for utilization of health services



Source: Secondary

2.1.2 Conceptual Framework

The figure shows the relationship between the independent variables and how it affects the dependent variables of the study. Having looked at the above figure the independent variables like the disposing, enabling and the need perspective affect the dependent variables in this case the rights of the women to maternal health. The independent variables affect the dependent variable in both negative and positive way. Where if the characteristics of the dependent variable are negative, for example if in the disposing factor there is too much influence of culture on women, low education level, this will lead to low knowledge, low accordance and high level of factors inhibiting accordance of rights. Same will apply to enabling characteristics and need based characteristics. For example where there is high household income, this concept assumes high level of accordance, high knowledge and low

factors inhibiting compliance. In one way when the element of disposing factors like education of the women in a given area is low there will be low knowledge, low accordance and if the level of education is high it will be vice versa. On the other side if enabling characteristics such as income of a household is low there will be low accordance, low knowledge and increased factors affecting accordance will be reduced due to lack of availability of money to access ANC. If the level of the income is high there will be high knowledge, high accordance and reduced factors affecting accordance. From the concept point of view this studies predisposing, enabling and needs based characteristics inform the study to investigate level of knowledge into rights of women to maternal health. The study also investigated the level of accordance of the rights of women to maternal health using the same procedure as indicated in the concept and factors affecting the according the rights of women to maternal health of Juba County.

As revealed by several studies and national surveys, lack of courtesy and respect in health facilities and perceived poor quality of care are linked to low uptake of maternal health care services in almost all geographical regions of the countries in Africa and other regions of the world Taregen (2014).

In the concept above under the independent variables there are three level of characteristics that affect the access to maternal health facilities. These are seen to be the predisposing factors which include demographic and social factors. In the part of the demographic characteristics of the Mothers attending ANC this study explored things like age, gender/sex and marital status as biological imperative to be influencing the needs to get the services of ANC as guided by this concept to determine access of women to attend ANC. Other disposing factors such as the social factors like education, occupation, ethnicity to be social factors added onto this were also mental factors that cover the belief of the mothers (Birgit et al, 2012). This is important in this study because these elements provide knowledge about

maternal health of women which knowledge contributes to level of information about maternal health of women in Juba County.

Addition to the disposing factors as added by Targen (2015) was evidence with the presence of hostile or insensitive staff, disallowance of birth companions, disrespectful care, women's lack of autonomy and privacy, inadequate facilities in labor wards, and abuse by staff are among factors deterring women from accessing ANC care and facility based childbirth. In the study done by Taregen (2014) regard this kind of treatment characterized by disrespect and abuse which not only discourages women from attending for facility-based deliveries but also denies their rights to high quality childbirth services as declared by the United Nations

Enabling factors such as the Financing and organizational factors are considered to serve as conditions enabling services utilization allowing the utilization of maternal health for mothers. This helps them achieve their rights to maternal health. This looks at the way the household's ability to pay for the basic administrative fee that the individual could be required to pay in order to be accorded the rights to access to the utilization of maternal health services as an element of their rights to health. This individual or household financing factor enables the mothers seeking ANC services to be able to cost share with the government in payment of the administrative fees. The enabling factors also include the organization from the part of the mothers on matters such as transportation to the facilities where these services are obtained. These factors contribute to accordance of maternal health service ensuring the rights to maternal health obtained. Other factors of organization from the household to enable the ANC attendance from accessing the health facilities include time factors, distance covers during this travel and the procedures involves in order to have access to the facilities enabled. At the contextual level, financing encompasses the resources available within the community for health services, such as per capita community income, affluence, the rate of health insurance coverage, the relative price of goods and services, methods of compensating

providers, and health care expenditures. Organization at this level refers to the amount, varieties, locations, structures and distribution of health services facilities and personnel. It also involves physician and hospital density, office hours, provider mix, quality management oversight, and outreach and education programs (Brigit et al 2012). In the context of this studies therefore these enabling factors play crucial parts to ensure the mother have access to the most basic maternal health service helping them realized their rights to maternal health.

Andersen and Davidson as cited in Rice (2001) differentiate issue between perceived need and elevated need for maternal health utilizations. In the perceived need of the maternal health utilization, they looked at how an individual ANC attendant looked at the need to get access to ANC based on their own experience and how the symptom of illness as a result of not attending ANC affect their individual health. So if the perceived need is low in the community there low level of knowledge , low level of accordance and high factors inhibiting the accordance of the rights to maternal health. While in the elevated need they look at the professional assessment on an individual and the objective measurement of the patients' maternal health need. Looking at this and based on the concept for this research. The need factor play equally an important role as women paying ANC visits and have knowledge about the need of maternal health services can be influence with what they feel in themselves. But this differs in the element of the elevated need where professionals are ready and have full information to the ANC attendance. But most of the entire overall needs context is influenced by maternal health population indices where the overall need for maternal health is influence community health indices which amongst others included maternal health indicators of mortality, morbidity and disability to have access to them.

2.2 Review of the Literature

2.2.1 Introduction

In this chapter a review of the relevant literature about rights of women to maternal health is presented. The literature presented is in relation to women's knowledge about maternal health rights, the extent to which they are accorded maternal health rights and the factors inhibiting maternal health care accordance to the women with respect to the study objectives.

2.2.2 Level of knowledge about maternal health rights

Effendi, Isaranurug, Chompikul (2008) establish knowledge in relation to maternal health as the main driver towards permitting women to become aware of their maternal health rights. Effendi and the colleagues thus articulate the fact that such knowledge about maternal health rights allow for such women to seek maternal health services that are appropriate to them. Unfortunately Effendi and the colleagues fail to provide information about the level of knowledge about maternal health rights.

Gruskinet al (2008: 590) noted, slightly ahead of the effort to combat maternal mortality within the domain of public health and international feminism especially those in the center of women activism around the areas of human rights both within countries and globally was growing. The early demand of women movement particularly in Western Europe and North America focused on two key demands; equal pay for work of equal value, and the rights of women to have control over their bodies and to have access to contraception and abortion. By around 1980 the health stream of international women began to come together and call for the needs for right to health through the International Women and health meeting which for the first time brought women together from all over the world Gruskin, et al, (2008). Amongst the key issues, which brought together women from all walks of life, was the demand for access to emergency contraceptive and access for antenatal care and safe childbirth. Closely

linked to this was the demand to abolish population control measures, which at that time was being imposed on women by most governments in the globe.

Igbokwe (2012) establishes that the level of knowledge in as far as maternal health is concerned as varying from place to place across the world. Igbokwe particularly finds that other than the majority 87.7% of the women of the child bearing age being aware of the benefits of antenatal care, up to 25.9% of the mothers had a fair level of knowledge in as far as the activities associated with antenatal care was concerned. The author also finds good knowledge amongst 69.9% and poor knowledge among the minority 4.2% of the women about the maternal health activities. The author however remains unclear as to the level of knowledge amongst the women of the child bearing age with regard to maternal health rights which gap this study explored to fill.

Ojo (2004) finds that the majority 95% of the women were knowledgeable about the importance of being examined during antenatal visits in Tunisia. This was however refuted by Maputle et al., (2013) who reports that up to 73.9% of the women of the child bearing age lack enough knowledge with regard to antenatal care. None of these studies were particular to the knowledge in reference to maternal health rights which gap this study explored.

In another development Gurmesa (2009), reports the majority 65.6% of the women as being knowledgeable of at least a half of the issues with regard to maternal health in Metekel zone, North West Ethiopia. This study however suffers from the disadvantages associated with cross sectional design such as the factors inhibiting the accordance of rights to maternal health, which gap this study explored.

Akpan-Nnah (2011) finds that health workers abused maternity care practices and were demonstrating risky practices related to maternal health care such as taking all the necessary tests during antenatal visit in public health facilities in Eastern Cape, South Africa. This study

however only made observations and interviewed nurses, managers and other key informants leaving out the women who are affected by the maternal health issues.

Asuquo et al (2000) find most women were abhorred with the attitude of hospital staff towards patients given their rudeness alongside shouting and scolding. This by implication meant that the women had a right to being handled fairly when seeking maternal health services. While this study provided in-depth results given that it was qualitative in nature which means that it fails to ascertain well the level of knowledge on maternal health issues which require quantitative approaches.

Grossman-Kendall et al (2001) find many women complaining about not being able to ask questions and getting explanations, and being mistreated and humiliated by health personnel in Benin. Much as this study meant the women had some knowledge about maternal health rights, it only involved 19 women participants which make it unrepresentative in nature.

In a small quantitative survey of 220 women with childbirth experience by Kempe et al, (2010) in Yemen, the researchers reported that while personal empowerment at birth is very important to Yemeni women, the women's perceptions are that skilled birth attendants worked against their personal authority, did not give them emotional support, and did not answer their questions or requests. Most women chose to deliver at home because of fear of bad experiences or prior bad experiences of institutional deliveries.

In the research carried out by Kendall, T (2015) he noted that there is a sufficient coverage of the maternal health care in the facilities across Asia with the intention to give knowledge to the community in Asia in regard to rights to maternal health. But he noted that this coverage alone did not give sufficient knowledge about the issues pertaining the rights to maternal health. He noted the respondents in his research saying that this coverage are there but it is hard to guarantee the quality of care given to the women at facilities in the rural areas. He argued that much as there was limited knowledge about the rights to maternal health through

the coverage, there was an urgent need to widen up information about the rights of women to maternal health even at grassroots level. This research was categorical though it has gap in what specifics information is need to have the health care system improve for women to get the much needed rights to maternal health.

Kempe et al, (2010) find that skilled birth attendants worked against the personal authority of the women during child births in Yemen. Kempe and the colleagues particularly find that the skilled health workers did not only provide the women with emotional support but also failed to answer the women's questions yet it was their right to know during and after childbirth, their rights to maternal health. Kempe and colleagues argued that women ability to ask some questions in Yemen cited there is an evidence of knowledge since they had the intention to seek by asking questions in order to know more though they were let down by not providing the information they needed.. This study was however quantitative nature implying that it did not do enough for the women to express their views freely.

2.2.3 Accordance of maternal health rights to the pregnant women attending ANC

Bohren et al., (2014) find that pregnant women are poorly accorded maternal health rights as reflected in the mistreatment of the pregnant mothers during childbirth. This is supported by the likes of Chadwick et al., (2014) who find the issues with the health workers being abusive, the issue of disrespectful care and neglectful as some of the poor accordance to maternal health rights to the pregnant women that attend antenatal care. None of these studies were however particular to South Sudan.

World Health Organization, (2014) also establishes mistreatment during childbirth as demonstrating a violation of the fundamental human rights of the women when seeking maternal health care. The organization understands such mistreatment is more of a disincentive for women to seek care in facilities for their subsequent deliveries thus promoting denial of maternal health rights. The World Health Organizations thus

recommends that respectful care be accorded during maternal health care as it allows friendly birthing in the health facilities where care is sought. This study was looked particularly on the items of birthing leaving of other maternal health care rights such as those related to antenatal and postnatal care.

Kendall, T (2015) stated in his research that one way to improve the accordance of the rights to maternal health as supporting women empowerment. He noted areas such as evolution of intervention to economically improve the standard of women by process such as cash transfer and conditional cash transfer, voucher of transportation and improvement of maternal health services. He further mentioned another element of empowerment is the introduction of mechanism that transforms the relationship between the pregnant women and that of healthcare providers. This research was categorical but it lack empirical evidence that when pregnant women are financially empowered they could improve accordance of maternal health to fellow women or even for them.

Potts, H (2008) reported that as a measure to improvement of maternal health services there is need to monitor Maternal death reviews, which are community and/or facility based, systematically examine the incidence and prevalence of maternal mortality and morbidity, thereby enabling health professionals to review the treatment provided and identify ineffective medical practices. Community-based maternal death reviews can establish the cause of death and illuminate any personal, familial and/or community factors contributing to the death. Generally, in such reviews trained field-workers interview family members and others who can help to identify factors leading to maternal death and noted generally a low knowledge about the rights to maternal health. Though she further noted this community level discussion can facilitate the introduction of measures to prevent maternal deaths and disability. This according to her includes Facility-based reviews are qualitative, in-depth investigations of the causes of, and circumstances surrounding, maternal deaths which occur

in healthcare facilities. Implementation of maternal death reviews affect policy change and improvement in the quality of maternal health services. They also serve as a baseline to measure progress in reducing maternal deaths and disability. However, in order to increase accountability, an independent body with authority to oversee State action and to verify the implementation of recommendations, must review the data to ensure the provision of objective, non-biased analysis and recommendations to policymakers. However these facility based policy analysis and measures to improve maternal health were not indicated in her research this is an indication there limited knowledge about the rights to maternal health.

Yamin, (2010) agrees with suggestion that the circle of accountability for states should complement the declaration of right to maternal health as a human right should be included in national laws and must have clear strategies of implementation for development and implementation of a national plan of action. Any person who violates the right to maternal health or anyone found guilty on the issue as violence, rape and many others should be held accountable by law. Meaning there must be clear boundary of budgetary analysis, monitoring and evaluation of programs based on appropriate indicators and mechanisms for redress. However there is a gap since this research did not include the measures of the accountability required by the states to monitor noncompliance of the maternal health service providers.

Freedman and Kruk (2014) report the accordance to the rights of maternal care as being in the negative circles. The authors particularly find that the seeking of maternal care is characterized by not only disrespectful but also scenes of and abusive childbirth interactions. This is supported by the likes of Bowser and Hill (2010) who establish maternal health as being characterized by more of an abusive care particularly during childbirths. Bowser and Hill particularly find the pregnant women as being abused physically yet sometimes

discriminated and abandoned which limits accordance of maternal health rights. The result in these two research study were not in the scenario cases of South Sudan.

In another study Freedman et al (2014) equally find that maternal health rights are not accorded to the women of reproductive age in the right way. Bowser and Hill (2010) equally elucidate this by arguing that the maternal health care that is characterized as disrespectful however tends to lack proper standards with no clear agreed typology to classify as discouraging provision of maternal health care. These studies are however much contradicting in that while one points towards maternal health care accordance issues, the other questions the classification.

According to International Journal of Human Rights (2010), the accountability of the state to maternal health relates to the right to protect, respect and fulfill which are elements covers in the civil and political rights as well as the economic and social rights. It will be narrow to look at maternal mortality in the context of women's economic status but this goes beyond to issues such as gender inequality and violation of women sexual and reproductive rights that constitutes a gross injustice leading to maternal death. So when this kind of injustice happens it calls for element of responsiveness, answerability and redress. The traditional mode of accountability that looks at the violator upon the death of woman in the process of childbirth give summary dismissal for the medical personnel who attended the birth of the dead woman is the cause of the death is found to be preventable. This may look as a fair way of accountability but it rather creates misunderstanding, as most of these kinds of accountabilities are not documented.

In another study undertaken in Tanzania, Kruk et al. (2014) find that up to 19.5% of the women mistreatment during childbirth which is derailing to the accordance of maternal health rights. Kruk and the colleagues specifically establish that the mothers were shouted at, scolded and also physically abused let alone the non-dignified care that is experienced which

implies less accordance of the maternal health rights. This study was however based of self-reported experiences of the women particularly during a facility exit survey and at follow-up which leaves out the views of the health workers.

Sando et al. (2014) establish that while women are accorded maternal health rights, the highest proportion of women were mistreated that derails such accordance were among those that were HIV negative but lowest amongst those pregnant women that were HIV positive. Sando and the colleagues however find not being provided with privacy highest in HIV-negative women (94.4%) but lowest in HIV positive women (91.3%) and women are not asked to consent to vaginal examination highest in HIV-positive women (100.0%) and lowest in HIV-negative women (79.8%). These results were however contradicting between those pregnant women who were HIV-positive and those who were HIV- negative.

Okafor et al. (2015) find negative accordance of maternal health rights to the pregnant women that were attending antenatal care. Okafor and the colleagues particularly find that most of the women almost experienced some kind of mistreatment during childbirth (98.0%) which implied high disincentive to maternal health rights. The mistreatments that were derailing to maternal health care accordance included but not limited to either being beaten, pinched or even slapped. This study however suffers from issues of representativeness as it was based on interviews that were conducted with a convenience sample of women that were accessing newborn services at an immunization clinic in Nigeria.

2.2.4Factors inhibiting accordance of maternal health rights of the pregnant women

Douglas and Douglas, (2004) find the lack of privacy in the health facility as one of the central factor that leads to a loss of dignity inhibiting accordance of maternal health rights of the pregnant women. Douglas and Douglas also report the behavoiur of the health care staff members alongside the physical structure of the health facility that is faulty resulting in

inadequate privacy and personal space as some of the factors that are inhibiting to according maternal health rights of the pregnant women. This is supported by the likes of Seed house and Gallagher, (2002) who in their findings report small bed spaces leading to the close proximity of beds as threatening dignity and therefore inhibiting accordance of maternal health rights of the pregnant women. These results were however undertaken in hospitals within England which is much different from the case of South Sudan.

In another research by Brinkerhoff, (2003:7) it expresses the concern of corruption in budget of maternal health as factor inhibiting the accordance to maternal health. This budgets are setup by the Ministry of health and disbursed to the line Ministry to the Hospitals to help implement maternal health related issue but the way the money is used is not clear as this is not accounted for the hospital administration. This means if an allocation is given to maternal health a clear reflection should be indicated on how it was spent. This budget works as a tool that holds government accountable towards improvement of maternal health. However in a nation sometime substantial resources exist that could be directed to health sector but could not be rightly channeled due to varying factors this he indicated is one factor inhibiting the compliance to maternal health service provision. He further mentioned other factors that could range from lack of the required human resource capacity to absorb resources and use the resources as planned, ineffective investment of funds where these funds would be directed on another issue instead of maternal health issue, weak financial management where corruption issue could take a lead especially in the developing countries, poor procurement practices, limited oversight, and poor district level management in decentralized health care system. So when this happens it is very important for the budget line to be very clear pointing areas of the allocation for purposes of directives. This research categorically indicates those factors inhibiting compliance but did not include the methods to reduce the bad practice hospital administrators could be imposed to so as to provide the best services.

Woogara (2004) finds that lack of privacy does not inhibit accordance of maternal health rights of the pregnant women but the open nature of wards which are designed for observation. This is supported by earlier study undertaken by Rylance (1999) who finds that physical structure of wards have a negative impact on patients' dignity in children's wards. These results are however contradicting.

In another study Johnson (2005) finds poor designs of the structures as providing unacceptable privacy levels which are much inhibiting to the accordance of maternal health rights of the pregnant women. In support Jacelon, (2003) finds that there is sharing of bedrooms amongst patients which is different from what happens at homes thus resulting in the loss of privacy which inhibits women from securing their maternal rights. These results are quite contradicting in a sense that latter studies is viewed from the perspective of the patients in general other than the pregnant mothers.

Street and Love, (2005) find that communal use of rooms inhibited accordance of maternal health rights amongst the pregnant women. This was in agreement with findings from the likes of Woogara, (2004) who establishes that single rooms offered greater privacy. The latter study is only an assertion that needed to be empirically ascertained.

Earlier studies for instance by Shotton and Seed house (1998) indicate scarce resources as one of the factors that inhibit accordance of maternal health rights amongst the pregnant women. In accordance with Shotton and the colleague, inadequate linen in health facilities threatens dignity resulting into depersonalization of care. Different however Gallagher and Seed house (2000) establish the issue of poor physical environment as reflected by the inadequacy in bathrooms alongside toilet as threatening dignity. The two studies are however contradictory in their findings which gap this study explored to fill.

Calnan et al., (2005) find shortages in staffing as affecting the dignity of the patients in a health care facility. The author argues that the staffing of a health facility can result into a loss of continuity in care provision let alone the increased likelihood of dignity. In agreement Walsh and Kowanko, (2002) report shortages in staffing as making the patients to feel rushed besides being valued less as human beings which inhibit accordance of maternal health rights of the pregnant women. This is also supported by the likes of Reed et al., (2003) who find shortages in staffing as negatively affecting ones dignity. All these studies were however not particular maternal health care seekers.

Tadd, (2004) establishes that a care environment diminished individuality which was also inhibiting to health rights. In support Woogara, (2004) also reports the environmental culture amongst which is social norms of staff members , policies, systems and accepted practices as being pertinent and detrimental if negated to accordance of health rights. These results were however focused on the older people leaving out the views of the pregnant mothers. The former study was based on the views from the focused discussion groups which results suffers from problems of generalizability while the latter study looked at policies instead of the pregnant women.

Woogara (2004) finds the culture of the health facility as influencing the way maternal health rights are accorded to the pregnant women**.** The author particularly finds not only loss of control but also preparation of waiting list targets as threatening the dignity of the patients. This study however lacks information on how such culture within the organizations influences maternal health rights, which gap this study explored.

In another study Woolhead *et al*., (2005) establish that the issue of according health rights is affected by exposure of not only bodies but also failure to ensure privacy unintentionally by the health care staff within the health facility. This according to Woolhead and colleagues threatens the dignity of particularly older people. In support Lai and Levy, (2002) identify

failure to provide privacy but also in an unintentional way as derailing proper accordance of maternal health rights to the women in labour. What is unfortunate is that while the former study remains silent about the pregnant women, the latter study does not reflect accordance of maternal health rights in the antenatal case and post natal cases.

Kiporonh K, M (2005) noted in his research the attitude of medical practitioners, procedures and the cost associated with the different tests during the ANC visit as a major factors inhibiting the accordance of the rights to maternal health. In his research carried out in Western Kenya he noted that pregnant women get information that tests are free but when they reach the health facilities they are not accorded the required tests simply for the reason that they are not able to pay. He further noted in his finding that health workers have poor attitude towards the pregnant women adding that for mere late reporting nurses would refuse to attend to the pregnant women. This research shows a gap in passing clear and transparent information to the clients, the pregnant women during the ANC.

Matiti (2002) establishes that while privacy is important but not intruded by the health care workers themselves, in several health care settings many 'health care staff members fail to always uphold to the provision of privacy to the patients even in the light of patients' vulnerability and dependence in the healthcare setting. The author also identifies the varying preferences expressed by patients as also some of the factors that influenced health rights accordance to the patients. In disagreement however Giaquinto (2005) finds the frequent use of power by the nurses as health care workers as negating how health rights are provided to the admitted in rehabilitation wards. These two studies remain contradicting in reality moreover both are not particular to the pregnant women.

Tadd, (2004) also finds the issue of the older patients being spoken to as if they were deaf, unintelligent or children as being consequential to health rights accordance as it demotivated seekers. This is also supported by the likes of Wool head et al., (2005) who argued that patients being addressed by endearments renders them seem small. None of these studies are however particular to maternal health and to be more specific to the women.

Enes, (2003) finds the issue of ignoring patients as retarding the issue of according health rights to those seeking health care. Different however Calnan et al., (2005) report harshness as the most detrimental factor inhibiting accordance of health rights. In the same way a study by Werner and Malterud, (2003) find the practice of not treating patients as though they are credible as retarding the issue of according health rights to those seeking health care. These studies are however controversial.

Gallagher and Seedhouse, (2000) find the issue of vulnerability amongst the pregnant mothers themselves as allowing violation of the maternal health rights. However recent study by Bowser (2010) establishes normalization of disrespect and abuse during childbirth is another factor inhibiting health workers to comply with maternal health rights. To Bowser such normalization renders women to be less likely to have sufficient knowledge or to be empowered to speak up for themselves and demand better treatment. These studies were not particular to health facilities in South Sudan.

Warren (2012) also establishes disrespect and abuse of the women by the health care workers as one of the factors that are known to negate accordance of health rights in facilities within Kenya. Sando, (2013) however finds lack of community engagement and oversight, taxes and other public fees as some of the factors that are known to retard to the accordance of maternal health rights. These studies however reported contradicting factors.

The other study for instance by Thaddeus and Maine (2004) the lack of financial resources is a well-documented barrier to compliance of health workers with maternal health rights. Thaddeus and Maine particularly find that the inability to pay user fees derailed the pregnant women from being accorded health care rights. In support Bangser et al, (2011) find demanding money for blood transfusions, and refusing to provide care until a patient provided the worker with a soda as a barrier to according maternal health rights in Tanzania. The latter study was based on few pregnant mothers as it was qualitative in nature.

Bowser and Hill (2010) also establish the lack of autonomy and empowerment as another factor inhibiting health care workers to comply with maternal health rights. To the authors while there exist little evidence in as far as respectful maternity care is concerned, such lack of autonomy and empowerment which is intimately linked to normalization of disrespect and abuse requires to be addressed if health rights are to be well accorded.

In a more recent study Delayehu, (2013) reports health workers prejudice as the other factor inhibiting health workers to comply with maternal health rights. To Delayehu when health workers sometimes harbor prejudices based on the ethnicity, age, educational status, religion, economic status and HIV status, accordance of maternal health rights is derailed. In agreement Matthews et al, (2010) finds ruddiness, neglect, and abusive care as limiting accordance of health rights in the urban facilities of Tanzania.

The study results by Leape et al (2012) point out health workers distancing as a result of training is another factor inhibiting accordance of maternal health rights. Leape and the colleagues argue that health workers practice the behaviors that are disrespectful and abusive learnt during their training which demotivated patients from being accorded maternal health right. The Center for Reproductive Rights, (2008) however find that health workers being

often under-paid and, particularly in rural areas let alone the little opportunity for career development and advancement as limiting accordance of health rights. Again the results of these studies were quite controversial as it talks about distance and underpayment.

Johnson L.S (2010) reported that another factor that inhibits the accordance of the right to maternal health as the tendency of states of not separating the rights to health with that of the rights to maternal health. He regarded this as the greatest unresolved problem of our time since the rights to maternal health is an integral part in reducing maternal mortality. According to Johnson, leaving the rights to maternal health as the rights to health may make state define the rights to health in a different way in which it can ignore some specific needs of the pregnant women. One example of this definition which Johnson L.S (2010) included in his work was the state run family planning program may look like the rights to health but it has specific aim at family planning not the specifics of maternal health. This view is categorical but the finding are not so specific to the situation in Juba County as the government in the newest state does not consider so much the issue of family planning. More so the mixture of rights to maternal health and that of rights to health cannot be a serious factor inhibiting the rights to maternal health is the components of maternal health is consider as a core element of human rights to the health of woman.

Miller (2003) finds out that another factor inhibiting health to comply with maternal health rights is the lack of standards. The author finds that in most health facilities, while the standards for maternal care are focused on evidence-based clinical practices, less attention is given to standards of interpersonal care or the patient-provider relationship. However Woogara (2004) reports general lack of courtesy towards patients as limiting health rights accordance. But Nordenfelt, (2003) establishes extreme behavoiur by the health staff as threatening accordance of maternal health rights to the patients. These results based on the review are however controversial.

Leape et al (2012) also find that lack of leadership and supervision for respectful maternity care as another factor inhibiting health workers to comply with health rights. Leape and the colleagues conclude that in the absence of strong standards for respectful maternity care, weak leadership and supervision are particularly problematic. The CARE International report (2009) points out the other factor inhibiting accordance of health rights as lack of accountability mechanisms. In particular Care International identifies the accountability mechanisms as complaint boxes and the incident reports that are designed to hold providers responsible for the quality of care they provide. The studies were however not particular to pregnant women.

Fathalla, (2006) reports the lack of existence and enforcement of national laws and policies coupled with disrespect and abuse are fundamental violations of ethical and human rights principles as the other factors that inhibit health facilities to comply with maternal health rights. Leape et al (2012) however finds that health workers status and respect as the other factor inhibiting health compliance with maternal health rights.

In another study Miller et al, (2003) find the issue of inadequate infrastructure, human resources and limited supplies as the other factors known to be inhibiting health to comply with maternal health rights. This according to Miller and the colleagues is also inhibited by the demoralizing healthcare providers which is eminent. This study however looks at the patients in general it has not addressed the rights of women to maternal health.

2.2.5 Summary

The results based on the careful review of the studies show a general agreement that the level of knowledge in as far as maternal health varied from place to place in some places low though in some places moderate. Most of the reviewed studies are however unclear as to the level of knowledge amongst the women of the child bearing age. There is also a general agreement that the pregnant women are poorly accorded maternal health rights as reflected in the mistreatment of the pregnant mothers during childbirth. The studies also highlight the fact that women mistreatment, being shouted at, lack of privacy and poor designs of the structures among others derailed accordance of maternal health rights to the women. Unfortunately some studies were either controversial or not particular to the pregnant women, which gaps this study clarified. The foregoing reviewed studies were also done in other countries other than South Sudan.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.0 Introduction

This part presents the research design, study area, study population, sample and sampling design utilized by the study. It provides data sources, collection tools, collection procedure, data presentation and analysis. It also presents the quality control measures and the limitations to the study.

3.1 Research Design

Ogula (2005) defined research design as a plan, structure and strategy to obtain answer to the questions and control variance. In this study, a cross-sectional study was adopted. According to Bethlehem (1999) cross sectional design has three features. That it has no time dimension, reliance on the existing difference rather than change identified following the interventions. He further noted that cross sectional design measures difference variety of people phenomenon subjects than process of change As such, researchers using this design can only employ a relatively passive approach to making causal inferences based on findings. The advantage of cross sectional studies is that, they are quick and cheap since data is collected at once and multiple outcomes can be studied hence less resources are needed to run the study. This method was chosen because it collects information from a sample and makes measurements at one single point in time. Both qualitative and quantitative approaches were used. The qualitative approach was adopted because it allows an in-depth elicitation of the phenomena under study as opposed to quantitative approach which was chosen because it enables the researcher to explain the phenomena using numerical figures. Marsh (1983) stated that quantitative research provides information that is adequate and at the level of meaning.

3.2 Study Area

Study area is the geography from which the data is analyzed (Civic Technologies 2007). The area of the study is Juba County. According to the Wikipedia of Juba County, Juba County is located in Central Equatoria and currently serves as the capital city of South Sudan and Administrative capital of Central Equatoria. According to the disputed population census that was conducted in 2008, the population of Juba County is 372,413. Juba County is located on the west bank of river Nile about 87 miles south of Bor. It is the commercial center for Agricultural produced in the surrounding Counties. It is a high way hub connecting Uganda from South, Kenya from South Eastern and DRC Congo from the West.

3.3 Study Population

In the definition by Ogula (2005), study population is the group of institutions, people or objects with common characteristics. The study targeted pregnant women who were attending antenatal services in Juba County. A total of 310 constituting 140pregnant women fromJuba teaching hospital, 20fromKator PHCC, 20from Lalogo PHCC, 30from Rokon PHCC, 10Kuda PHCC, 25from Lobonok PHCC, 15from Nyakuron PHCC, 35 from Gurei PHCC, 10from Katigiri PHCC and 5 from Tijor PHCC were targeted in 5 days study time. This therefore implies that a total of 310 women were targeted in a period of one week considering 5 working days, Monday to Friday during the study time. The inclusion criteria constituted all pregnant female aged 15 to 45 years who were attending the antenatal clinic in health facilities and provided informed consent during the study period while those that were too sick to respond was excluded.

3.4 Sample Size

In the definition by Mugenda and Mugenda (1999) Sample is a smaller group or subgroup of the accessible study population. To Brog and Gall (2003) at least 30% of the targeted study population is representative. In research studies, a sample is viewed as collection of some elements of population. In other words, a part of totality on which information is generally

collected and analyzed for the purpose of understanding any aspect of the population. Whereas in research and particularly, sample determination remains the complicated task as what should be the size of the sample or how large or small should the sample size be, when the sample size "n" is so small, it may not serve to achieve the objectives and if it is so large, incur huge cost and waste of resources are bound to be incurred. However as a general rule, one can say that the sample must be of an optimum size that's it should neither be excessively large nor too small. In this study after putting in consideration all the above, the study adopted Sloven's formula for sample size determination as suggested by Yamane (1973) as shown below. This formula was chosen because the targeted population size was known.

$$n = \frac{N}{1 + N(e)^2}$$

Where N = the target population (310)

n – Desired sample size

e= level of significance/precision 0.05 and 95% confidence level

$$n = \frac{310}{1 + 310(0.05)^2}$$

$$n = 174.6478873$$

$\approx$ 175 women

Therefore a total of 175 pregnant women attending the selected health facilities constituted the sample size of the study. In addition, 10 health workers one from each health facility constituted the study key informants.

3.4.1Sampling Procedures

In this study, the selection of the respondents followed both probability and non-probability sampling techniques. The health workers as key informants were chosen using non

probability methods specifically *purposive sampling*.In purposive sampling the researcher uses some factors that influence the population to sample the population such factors includes socio economic status, intelligence and knowledge in some specifics items in the research questions (Korb 2012). So this design is chosen because it enables the researcher to only select individuals that have the right information concerning the phenomena under study.

On the other hand, the selection of the pregnant women followed a *random sampling* approach.According to Katerina Korb (2012) in social Science means that selection was done without an aim, reason or pattern. It means some scientific procedures were used to show it was purely selected by chance (Korb 2012). This sampling technique was used in such a way that identical sheets of paper numbered 1 to 310were placed in a well decorated box and shuffled. Consenting pregnant women were requested to each pick 1 at a time without replacement. Only those pregnant women, whose papers have numbers 1 to 175were chosen. This random sampling technique is chosen because it does not only minimize bias but also allows equal participation.

3.5Data collection methods and instruments

The study made use of a number of methods during the collection of the data so as to provide answers to the research questions. In this case the Questionnaire and interview method as explained here below were used to collect the data.

3.5.1 Data collection methods

Questionnaire method:

Questionnaire is a set of survey instrument used in research for collecting data from the population about an issue that is happening within its area (Siniscalco et al 2005: 3). In this study, a questionnaire method was used to gather information about individuals in this case the pregnant women. Researcher administered questionnaires specifically designed with respect to the research questions were used during the data collection process. Questions

contained within the questionnaire were composed of both closed-ended and open ended capturing issues about knowledge about maternal health rights, compliance of the health workers with maternal health rights and the issues inhibiting compliance with maternal health rights. A total of 175 questionnaires were given out. This instrument was chosen because of its confidentiality capabilities and allowance of liberty to give the respondents' time to concentrate when giving their input.In addition, the method was chosen because it allows the researcher to collect a large amount of data in a relatively short period of time and is less expensive than many other data collection methods.

Interview method:

An interview is a conversation in which a researcher tries to get information from the interviewee and records it by herself or himself. A structured interview guide which allows a neutral probe as respondents are asked the same list of specific questions was used to collect data from ANC health care staff members as key informants.The in-depth interviews with the health service providers were conducted by the researcher in English. The purpose of the discussion was explained to participants by the principal investigator and an in- depth interview guide was developed and used to guide face-to-face in-depth interviews with the health service providers and notes were taken by the researcher during the discussion. Interviews lasted for 30 minutes each interviewee. This method was chosen because it allows a diversity of views to be collected.

3.6 Quality control methods

In this study quality control was done through a series of procedures to ensure reliability and validity.

Validity:

This study ensured validity through the use of triangulation approaches. In this case both quantitative and qualitative approaches to data collection were used. In particular the study

used more than one research instruments that's the questionnaire and interview guide in the process of data collection respectively. Besides a pilot study in order to ascertain and detect any ambiguities related to questions that are not easily understood or poorly constructed. From the remarks and feedback comments, the instruments was refined and improved upon to take care of the observed shortcomings, enhancing the validity.

Reliability:

Reliability of an instrument is the ability of the instruments to collect the same data consistently under the same conditions (Amin, 2005). The test retest method was used. This involved the researcher testing the same instrument twice on a specific sample and then correlating the recorded scores of the two administrations to check for consistency using T_1 and T_2 tests.

3.7Data management and processing

The quantitative data from questionnaires was then coded, entered and analyzed in the computer using the Statistical Package for Social Sciences (SPSS 19).

3.8 Data analysis

The data so collected using the questionnaires was analyzed using descriptive approaches. In particular frequency tables were generated for presentation purposes. The graphs were also used in the presentation of the results. These approaches were used because they allow detailed information and are easy to understand by the reader. The means and standard deviations were used to tell the level of knowledge among the pregnant women and accordance of maternal health rights by the health care staff to the pregnant women.

However for qualitative data, all responses were noted down and checked manually for completeness and consistency. The analysis of the qualitative data from the interviews was analyzed and presented using a narrative approach.

3.9Ethical Considerations

An introductory letter was got from East African School of Diplomacy, Governance and International Studies, Uganda Martyrs University which introduced the researcher to the relevant authorities in Southern Sudan Juba County in particular. The letter was delivered to the authorities who granted permission for the study to be carried out.

Before meeting the respondents, appointments were made with the heads of the different health facilities to explain to them about the study so that they can fix appointments and identify the respondents for the study. After being allowed, the researcher held one day training with five (5) research assistants to get familiar with the data collection tools, sampling procedure, record taking and required ethics to be followed during data collection. A total of 175 respondents were randomly selected and each pregnant woman participating in the study was requested to sign the informed consent form, before administering the questionnaire.

The selection of the sample following the guidelines of the inclusion criteria ensured that all those who met the inclusion criteria had a fair chance to participate in the study. The researcher and research assistants explained to the respondents the purpose of the study, its general objective and what was expected of them. Risks and benefits of the study were highlighted and confidentiality was assured. Respondents were also informed that participation is voluntary. Prior to giving consent, there was a period of questioning to ensure that the respondents fully understood the explanations, thereafter the respondents were requested to give consent. Informed consent was obtained from the participants and assent was obtained from participants who were aged 15 years and above before recruitment into the study. Non-accompanied female youths above 15 years of age were considered as mature minors and they would assent for themselves.

3.10 Limitations of the study

In this study particularly at the time of field study, certain difficulties were encountered which included:-

The relevant literature in maternal health and theories that point to maternal health rights was scanty in nature. In particular relevant literature on the level of knowledge was lacking. This was however solved through triangulation.

There existed a diversity of groups from which the data on maternal health rights had to be collected from. This rendered the use of one data collection method to collect the appropriate data inadequate to exhaustively collect views about maternal health rights. In this case triangulation of qualitative methods with quantitative methods served a much better purpose.

Another limitation was the unwillingness to quickly accept the access to government facilities to collect data from the part of the government authorities responsible for those facilities. These official had vested interest of their own related to money that made the researcher take long to have the access granted. This issue was solved by contacting the higher authorities at the Ministry of Health with explanation and show of the letter from the University to indicate what the research intends to do. All facility heads were then contacted from the Ministry to allow an access which was later granted.

Some part of the Community do not understand the need for the research due to their cultural behavior they requested their wives to hold off from answering the questionnaires. One or two communities within the county felt like the research was a political thing aimed at getting information from them to be used for other political motive. They felt the explanation made for them in regards to education was just intended to blindfold them. To win the idea of this community a translator of a local language was brought in to explain to the community

leaders the essence of this research which made them to get in to give the information required of them.

Looking at Juba County which was the population studied as compared to the data collected during the literature review, most of the data collected for the previous studies were from community setup that was not like that of Juba. This made it hard to get more relevant secondary data collected in the literature. This was not taken as a serious problem as these data were used to compare with the situation in Juba.

More so earlier studies done were from either rights based group, CBO representatives or other organizations so in this kind of case the information received will not be purely representative as compared to the study conducted in Juba County. However this information was used as comparison purposes and to get an understanding of the earlier research on the same subject matter.

In a graduate research, it is more useful when study limitations are more content and methodologically related than logistical!

CHAPTER FOUR:

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the findings in relation to the rights of women to maternal health in Juba County health facilities. It starts by providing results related to the demographic characteristics of the pregnant mothers who were attending ANC at study time. These are then followed by results about the level of knowledge on maternal health rights, the extent to which health workers' comply with maternal health rights of the pregnant women attending ANC and the factors inhibiting compliance with maternal health rights of the pregnant women in Juba County health facilities. The presentation of results was based on the research objectives and research questions respectively.

Response rate

Table 4. 1: The study sample size

Category	**Targeted sample(n)**	**Actual respondents**	**Response rate**	**Overall response rate**
Pregnant mothers	175	175	100.0%	100.0%
Health workers	10	7	70.0%	**85%**

Source: Primary

Mitchell (1989) as cited in Fincham (2008) response rated is calculated as the numbers of returned questionnaires divided by the total numbers of the size of the sample earlier selected. The study had a target of 175 pregnant mothers and 10 health workers within the different health facilities. It however received responses from all the 175 pregnant women who were targeted but 7 health workers. It in unison received 85% response rate constituting 175 pregnant mothers using questionnaires and 7 health workers using interviews.

This response rate has stands as an important element in informing the research about the investigation onto rights of women to maternal health and it is an evident that the proportion of the population is responsive. This size of the response rate is important as it informs the study and it was much easier to understand the target population since majority of the respondents were reached. The proportion of 85% is a very good response rate to represent the populations under study.

Table 4. 2: Demographic characteristics Women Attending ANC in Juba County Health Facilities

Demographic characteristics		Frequency (N = 175)	Percentage (%)
Age in years	15-25	20	11.4
	26-35	100	57.1
	36 & Above	55	31.4
Marital status	Single	35	20.0
	Married	126	72.0
	Widow	14	8.0
Education level	None	55	31.4
	Primary	80	45.7
	Secondary	26	14.9
	Tertiary	14	8.0
Trimester	First Trimester	28	16.0
	Second Trimester	64	36.6
	Third Trimester	83	47.4
Number of times of attending ANC clinic	1	58	33.1
	2	44	25.1
	3	23	13.1
	4	50	28.6
Parity	1	44	25.1
	2	40	22.9
	3	28	16.0
	4	62	35.4
	5	1	.6

Source: Primary

The study findings in table 4.2 above shows that the majority of the women were aged 26 to 35 years (57.1%). This is however compared to the minority of the pregnant women who

were aged 15 to 25 years (11.4%). The majority of the pregnant women being within the youthful age explain there is moderate accordance of some basic maternal health rights as they have the experience to demand for such rights since at this age they had some previous experience of the benefit of maternal health care services. Also this is an implication that at this age the knowledge about their rights to maternal health is moderate. It also means that at this age, the women did not get to know how the rights to maternal health could be accorded to them by the health workers. At the above age women in the county could be at their second or third delivery so they got to understand the benefit of antenatal visit. While the minority of the (11%) indicates that at this age bracket there is very limited or no knowledge about the benefit of according maternal health.

The study results in table 4.2 above show that the most of the pregnant women were married 126(72.0%). The study however found the minority of the pregnant women were widowed 14(8.0%). Also the 20% of the women being single indicate that there is low accordance as a result of not being able to get the required help. Most women being married explained the good level of maternal health rights accordance on the basis these women had some previous experience for accessing the medical services during this period. At the same time these married women as a result of their age and level of Education had limited knowledge about maternal health and hence as a result they did not know much if there was compliance with their rights to maternal health by the health workers.

The study results regarding educational attainment in table 4.2 above showed most pregnant women who were attending ANC as a maternal health right had studied up to primary level of education 80 (45.7%) and those who had studied up to secondary level constituted 14.9% and 31.4% had not studied at all. The least proportion of the respondents had up to tertiary level 14(8%). This variation in the level of education shows that the low level of education could firstly inhibit compliance as it would take a long duration for a primary leaver to understand

the rules in compliance with the rights to maternal health but if they get to the hospital it is because they had the adverse effect they experience during their time of pregnancy. More so the fact that most pregnant women being less educated explained the low maternal health receipt amongst the women in Juba County since if uneducated, woman will hardly know she had the right to be accorded maternal health.

The study results also show that most women were in the second trimester 64(36.6%) as compared to the minority pregnant women who were in the first trimester 28(16.0%). Most women being in the second trimester implies they felt they have not yet reached a risky pregnancy level while at first trimester since at the first trimester did not have much complication. This negligence of the whole process is an evidence of low knowledge of the rights of women to maternal thus leading to low maternal health accordance to them as they did not seek the rights to get full information on the rights to maternal health. Women at this period are only forced to go to seek antenatal care when the sign of the pregnancy comprises of high fever, nausea and vomiting is disturbing them. This explains the evidence of limited knowledge of the rights to maternal health.

The study results showed that most pregnant women had ever been pregnant and carried such pregnancies to a viable gestational age for four times 62 (35.4%). The minority pregnant women had never been pregnant and carried such pregnancies to a viable gestational age for five times 1 (0.6%) this meant women with first pregnancy do not have knowledge about the rights to maternal health. The findings for those who gave birth before implied that during the previous pregnancy experience the women who gave birth before had some information about the benefit to get treated. In essence this meant that much as they had little or no knowledge about their rights to maternal health but the fact that in their previous experience they got the required antenatal services they felt there was need to get to health workers. This indicated that the women (who gave birth before) in this category are actually aware about

the need to get treated. This indicated they have knowledge that is not informed about the rights to maternal health but only seek the medical attention like any other need to get health care services. The seek for maternal health service was not actually as a right to maternal health but it was sought as any other health benefit to the pregnant women.

The study findings also show that most pregnant women had attended once in the ANC clinic 58(33.1%) as compared to the minority pregnant women who had attended three times 23 (13.1%). Such majority pregnant women having sought ANC services only once explain the low maternal health accordance to the women in Juba County. At the same time this explains lack of knowledge about the rights to maternal health amongst the majority of the women. The minority who sought ANC three times means there is a general low knowledge about the benefit to the rights to maternal health. Another implication to this also meant that as much as little knowledge they had amongst them, but also they lack information about the danger of not seeking health care during the three trimesters. This lack of information in Juba County impedes the accordance of the rights to maternal health.

4.2 The level of knowledge about maternal health rights among pregnant women attending ANC

The study irrespective of the background characteristics established the level of knowledge about maternal health rights among pregnant women attending ANC. The study results were as presented in table 4.3 below;

Table 4. 3: Level of knowledge about maternal health rights among pregnant women attending ANC

Maternal health rights	Strongly disagree N (%)	Disagree N (%)	Not sure N (%)	Agree N (%)	Strongly agree N (%)	Mean(S.D)
Right to healthcare before, during and after pregnancy and childbirth	5(2.9)	8(4.6)	0(0.0)	82(46.9)	80(45.7)	4.3(0.9)
Right to receive healthcare that is consistent with current scientific evidence	45(25.7)	34(19.4)	9(5.1)	67(38.3)	20(11.4)	2.9(1.4)
Right to choose a midwife or physician as my maternity care provider	27(15.4)	19(10.9)	1(0.6)	81(46.3)	55(31.4)	3.3(1.4)
Right to receive complete information about the benefits of breastfeeding	78(44.6)	32(18.3)	29(16.6)	31(17.7)	5(2.9)	2.2(1.2)
Right leave my maternity care giver and select another if I become dissatisfied with her care	81(46.3)	38(21.7)	7(4.0)	43(24.6)	6(3.4)	2.2(1.3)
Right to information about the professional identity and qualification of those involved with my care	46(26.3)	25(14.3)	15(8.6)	60(34.3)	29(16.6)	3.0(1.5)
Right to communicate with my caregiver and receive all care in privacy	23(13.1)	38(21.7)	3(1.7)	57(32.6)	54(30.9)	3.5(1.4)
Right to full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments	19(10.9)	19(10.9)	1(0.6)	81(46.3)	55(31.4)	3.8(1.3)
Right to accept or refuse procedures, drugs, tests and treatments	108(61.)	30(17.1)	7(4.0)	18(10.3)	12(6.9)	1.8(1.3)
Right to receive maternity care that is appropriate to my cultural and religious background	99(56.6)	45(25.7)	5(2.9)	20(11.4)	6(3.4)	1.8(1.2)
Right to have family members and friends of my choice present when attending ANC	59(33.7)	51(29.1)	14(8.)	37(21.1)	14(8.0)	2.4(1.4)
Right to freedom of movement during labor	41(23.4)	34(19.4)	15(8.)	70(40.0)	15(8.6)	2.9(1.4)
Right to decide collaboratively with caregivers when receiving	5(2.9)	8(4.6)	0(0.0)	82(46.9)	80(45.7)	4.3(0.9)

Maternal health rights	Strongly disagree N (%)	Disagree N (%)	Not sure N (%)	Agree N (%)	Strongly agree N (%)	Mean(S.D)
ANC						
Right to receive continuous social, emotional and physical support	58(33.1)	68(38.9)	10(5.)	37(21.1)	2(1.1)	2.2(1.1)
Right to be informed if my caregivers wish to enroll me or my infant in a research study	13(7.4)	37(21.1)	17(9.)	80(45.7)	28(16.0)	3.4(1.2)
Overall						**2.92(1.26)**

Source: Primary

The study found the pregnant women highly knew about their right to healthcare before, during and after pregnancy and childbirth 82(46.9%). These results compare well with those earlier found by Ojo (2004) that most of the women were knowledgeable about the importance of being examined during antenatal visits in Tunisia. The current results are quite similar to those earlier found by Gurmesa (2009), that most of the women were knowledgeable about maternal health as the new way to end maternal mortality and at least a half of the issues with regard to maternal health in Metekel zone, North West Ethiopia. Since it was earlier indicated that majority of the women who seek ANC are those who were pregnant before, the fact that majority of women have knowledge on their rights to maternal health during and after birth confirms the experience the majority of the women underwent in their previous pregnancies. Another implication to this is that women are aware of the need to seek health care service only before, during and after child birth but this does not explain whether they are seeking this as their rights to maternal health.

Most pregnant women highly knew about their right to receive healthcare that is consistent with current scientific evidence 67(38.3%), their right to choose a midwife or physician as their maternity care provider 81(46.3%) and highly knew about their right to information about the professional identity and qualification of those involved with the pregnant women's care 60(34.3%). These results are in agreement with earlier results by Kempe et al, (2010) that skilled birth attendants worked against the personal authority of the women during child

births which meant they were knowledgeable about their health rights. As confirmed earlier even from the characteristics of the population, the knowledge about the credibility of the health worker indicate that the women in Juba county have better information about the need to seek health care during and after child birth meant they needed a qualify personnel to attend to them. This also meant that the women have good knowledge about the rights to maternal health that is related to getting information about the skilled attendance, selecting the right health workers and the evidence based health care that is necessary for pregnant women. The implication to this is that this study is conducted in Juba County that is the capital of South Sudan so information on the skilled birth attendance is relevant and women get to know about the right health facilities to go to during this period.

The study also showed that the pregnant women were highly knowledgeable about their right to communicate with their caregivers and receive all care in privacy 57(32.6%). These results are quite comparable with those earlier found by Grossman-Kendall et al (2001) that many women were complaining about not being able to ask questions and getting explanations, and being mistreated and humiliated by health personnel in Benin. Complain about ability to communicate to the healthcare givers in this study indicated that the 32.6% of ANC seekers were aware of what is to be provided to them while attending the antenatal care. Also this indicated the same percentage needed to clearly be informed and ask question on any element of rights that is not accorded to them.

The results also showed that the pregnant women were highly knowledgeable about their right to full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments 81(46.3%). This meant for this study that the 46.3% of those women had source of information either from family members or they are attending to private clinics that provides them with such information on drugs, need for procedures and the benefit of tests.

However, most of the health workers during an interview agreed to some of the results as presented below;

> "*The women especially those who have ever given birth know that they have the rights to health care during birth, even during pregnancy……but they don't come*" [I2]
> "*…You can't tell but these women know that they are supposed to get the ANC services but due to negligence from the relatives of the delivering woman as they did not report …they refuse the pregnant mothers from coming to get the services*" [I3]
> "*…Some of the women know that they are supposed to get the maternal health services. They are even told by their fellow women that they should get the services as it is important for them during this period..."[*I1]

The results also showed that most women were highly knowledgeable about their right to freedom of movement during labor 70(40.0%), their right to be informed if their caregivers wished to enroll them or their infants in a research study 80(45.7%) and their right to decide collaboratively with caregivers when receiving ANC 82(46.9%). The results compare well with those earlier found by Effendi et al., (2008) that women had become aware of their maternal health rights. The results in the current study also compare well with those earlier found by Grossman-Kendall et al (2001) that many women were able to complain about not being able to ask questions and getting explanations which meant they had some knowledge about maternal health rights that were due to them.Most of the health workers during separate interviews agreed to some of the results as in the following quotation,

> "*Some ofthe women, know that they have to collaborate with the health care providers and have to move around during labour but only when directed by the midwife…..*" [I5]

Looking at the character and the level of education of the respondents, the uniqueness in the finding in this study was the knowledge for freedom of movement, collaboration and the rights to be informed which could rarely come with the characteristics studied. But the fact that most of the facilities studied were located in town it made it easier for them to acquire such knowledge about their rights as mentioned above due to available information they get from either colleagues or health professional within juba. Also this explain the role of nongovernmental organizations and civil society organization in and around Juba County in

providing such valuable information for women in regard to maternal health. Due to the war in the Country, International nongovernmental organizations and civil society organizations concentrated their effort and resources within the town areas so they deliver the required information in regard to maternal health for the pregnant women.

Most women however disagree to knowing the right to receive continuous social, emotional and physical support as a maternal health right 68(38.9%). Similarly most women strongly disagree to knowing the right to receive complete information about the benefits of breastfeeding 78(44.6%), the right to leave their maternity care giver and select another if they became dissatisfied with her care 81(46.3%) and the right to receive maternity care that is appropriate to their cultural and religious background 99(56.6%) as some of their maternal health rights. These results are in agreement with those earlier found by Asuquo et al (2000) who found that most women were abhorred with the attitude of hospital staff towards patients given their rudeness alongside shouting and scolding an implication that the women knew about their right to being handled fairly as a right when seeking maternal health services. These findings showed clearly states that the respondents were not aware about their social rights. It also evidenced that the care givers did not give awareness to the study population. If there were awareness they did not cover much about the social rights, and the rights to other social and emotional support. The study also meant no much attention was given to differentiate care appropriate with social and religious norm. It could also implied that the respondents do not have close attachment to religious and social norm and they are not bothered by such rights.

The study results show most women strongly disagreeing to knowing the right to have family members and friends of their choice present when attending ANC 59(33.7%) and the right to accept or refuse procedures, drugs, tests and treatments 108(61.7%) as their maternal health rights.These results fail to compare well with those earlier found by Maputle et al., (2013)

that most of the women of the child bearing age lacked enough knowledge with regard to antenatal care. To this research the above finding implied that the respondents are aware of some of their rights to maternal health but issues of whether or not to accept procedure and choose the person of their choice at ANC were some of the rights they were not sure if they were to be accorded.

In this regard the health workers during separate interviews had the following to say'

> "*Most of the women who come here donot know about some of their rights like the rights to refuse procedures or even drugs……..all they know is that they have to get treatment , issues of who is giving and how well those giving the treatment are trained, they don't know….*" [I4]
> *" Some but not all of the women know less about their right to receive … emotional or physical support… but they only see when it is there so they can't demand for it"* [I6]
> "eeee*…some women don't know they are delayed by the health workers to get the care deserved. They can't demand change of the health workers or procedures rather than use of rationality for treatment always resulted to mortality.."[*I7]

The study generally found a low level of knowledge about maternal health rights among pregnant women attending ANC services (Mean = 2.92, S.D = 1.26). These results are quite similar to those earlier found Igbokwe (2012) that there was poor knowledge among the minority 4.2% of the women about the maternal health activities. This therefore meant that since the women studied had low level of education, they also have limited knowledge on their rights to maternal health. General implication to this could mean that these women only have information to their rights to maternal though at a limited extent.

4.3 The extent of compliance with maternal health rights by health workers among pregnant women attending ANC

The study also established that extent of compliance with maternal health rights by health workers among pregnant women attending ANC in the different facilities within Juba County. The study results were as presented in table 4.4 below.

Table 4. 4: Compliance with maternal health rights by health workers among pregnant women attending ANC

Compliance	Never N (%)	Rarely N (%)	Sometimes N (%)	Often N (%)	Always N (%)	Mean(S.D)
I receive complete information about the benefits of ANC services	29(16.6)	50(28.6)	8(4.6)	68(38.9)	20(11.4)	3.0(1.3)
I access to healthcare whenever I come to this health facility	30(17.1)	27(15.4)	5(2.9)	84(48.0)	29(16.6)	3.3(1.4)
I choose a midwife or physician as my maternity care provider	41(23.4)	76(43.4)	20(11.4)	26(14.9)	12(6.9)	2.9(1.2)
I communicate with my caregiver and receive all care in privacy	29(16.6)	43(24.6)	15(8.6)	71(40.6)	17(9.7)	3.0(1.3)
I receive full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments	16(9.1)	76(43.4)	32(18.3)	36(20.6)	15(8.6)	2.8(1.1)
I receive maternity care that identifies and addresses social and behavioral factors that affect my health and that my baby	29(16.6)	50(28.6)	8(4.6)	68(38.9)	20(11.4)	3.0(1.3)
Overall						**2.91(1.28)**

Source: Primary

The study results showed that most pregnant women often accessed healthcare whenever they visited to the health facility 84(48.0%).These results are not in line with those earlier found by Bohren et al., (2014) that pregnant women were poorly accorded maternal health rights as reflected in the mistreatment of the pregnant mothers during childbirth. This means that since Juba Country is a capital city of the country, there is access to health facilities to most women in the County. The pregnant women often communicated with their caregivers and received all care in privacy 71(40.6%), received complete information about the benefits of ANC services 68(38.9%) and received maternity care that identified and addressed social and behavioral factors that affected their health and that of their babies68(38.9%). These results are quite different from those earlier found by Kruk et al. (2014), who found derailed

accordance of maternal health rights. The above differing result when compared this research in Juba County, the findings differs because due to the remoteness of the other party of the country, most health workers prefer to live in and around Juba so it was easier for pregnant women to communicate, get information on ANC benefit and many other benefits related to maternal health which therefore means that they were in compliance. In this regard one of health workers during an interview said the following verbatim,

> *"The pregnant women who came here are at least able to receive the maternal health services they are meant to receive …they complain but we give them what is necessary…."*[I2]
>
> *"….You are saying they don't……these pregnant women at least are able to receive the basic antenatal maternal health services*"[I3]
>
> *"I don't have to say for others but in this health facility the pregnant mothers and those delivering get the services except for sometimes when there are no medicines enough for all of them"* [I5]
>
> *"The women get maternal health facilities whenever they appear….they were some days delayed because some of the medicines are not there but they still receive the care they seek"* [I7]

The findings however showed that most pregnant women rarely chose a midwife or physician as their maternity care provider 76(43.4%). These results are similar to those earlier found by Freedman et al (2014) that maternal health rights are not accorded to the women of reproductive age in the right way as required by the pregnant women. The pregnant women have maternal health right rarely received full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments 76(43.4%). This means that during the ANC period the women have not been accorded the freedom to choose the caregivers, no clear information about the cost and benefits of drugs though they have the minimum information about their rights to maternal health so there is no compliance to maternal health. Some of the health workers during an interview had the following to say,

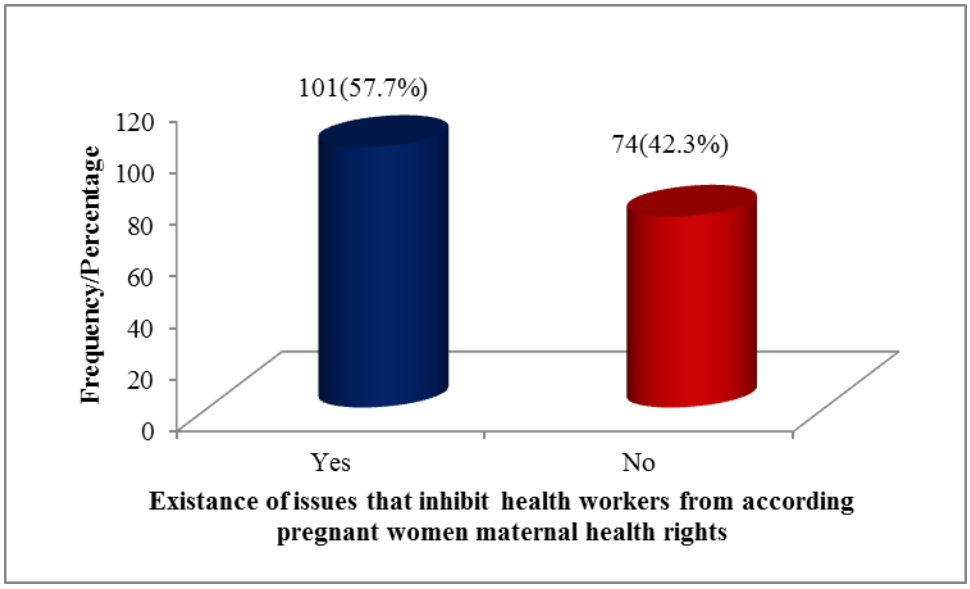
> "*….yeah in many instances there are few health staff so you cannot let the women choose their own health workers who are not there*"[I1]
>
> "*There is normally no time to keep explaining to each and every one about which medicine you are to give, its benefits you cannot explain to a lay person so ……for as long as she can be made fine*" [I6]
>
> "*…The problem…the tests are done according to the recommended standards …..the issue of explain we find no time*".[I4]

Overall results showed low compliance with maternal health rights by health workers among pregnant women attending ANC in Juba County (Mean = 2.91, S.D = 1.28). These results were similar to those earlier found by Bohren et al., (2014) that the pregnant women were poorly accorded maternal health rights as reflected in the mistreatment of the pregnant mothers during childbirth. The results are similar to those found by Chadwick et al., (2014) who points out that through health workers being abusive, disrespectful alongside neglect there was poor accordance to maternal health rights to the pregnant women that attend antenatal care. The overall implication of this study in compliance to the rights of women to maternal health is that the caregivers do not have time to attend completely to the pregnant women henceforth there is limited level of compliance since they only accord almost less to the most minimum standard required to comply with the health requirements.

4.4 Factors inhibiting compliance with maternal health rights by the ANC health care staff among the pregnant women

The study was also set to establish the factors that inhibited compliance with maternal health rights of the pregnant women by ANC health care staff. The study results as to whether there exists some issues that make the health workers not to accord pregnant women maternal health rights were as presented in figure 1 below;

Figure 2: Existence of some issues that make the health workers not to accord pregnant women maternal health rights



Source: Primary

The study results based on the majority of the respondent pregnant women showed that there existed some issues that make the health workers not to accord pregnant women maternal health rights 101(57.7%). The results in relation to the factors borne of the government that caused the health workers not to accord to pregnant maternal health rights were as shown in table 4.5 below;

Table 4. 5: Factors borne of the government that causes that limit maternal health rights

Inhibiting factors	Frequency (N = 101)	Percentage (%)
Few health staff	5	4.9
Improper legislation supporting health care services	22	21.8
Insecurity renders access to the health care hard	30	29.7
Limited funding from government	19	18.8
No drugs and facilities	21	20.8
Poorly trained health care providers	5	4.9

Source: Primary

The study found the factors that inhibited the health staff from according the pregnant women maternal health rights as few health staff 5 (4.9%), improper legislation supporting health care services 22 (21.8%) and insecurity which rendered access to the health care hard 30 (29.7%). These results fail to compare well with those earlier found by Douglas and Douglas, (2004) that lack of privacy in the health facility as one of the central factor that leads to a loss of dignity inhibiting accordance of maternal health rights of the pregnant women. The results however fail to compare well with those earlier found by Woogara (2004) that the culture of the health facility influenced the way maternal health rights are accorded to the pregnant women. The results are equally not in agreement with those earlier found by Woolhead *et al*., (2005) that exposure of not only bodies but also failure to ensure privacy unintentionally by the health care staff within the health facility as affecting accordance of maternal health rights. This findings meant that since Juba County is located in South Sudan the fact that the country is a new nation, it was not surprise that there were limited numbers of qualified staff to accord a better compliance to the rights of maternal health. It also meant to the pregnant women that proper health legislation had not been laid in place to monitor the caregivers from according the much needed compliance to maternal health. More meaning to this was the issue of insecurity that inhibited health care providers from having access to some remote places for the fear they could be tracked by the insurgents while delivering health care services. Another implication related to insecurity also could have prevented access to part of the county that could make it impossible for the access of things like ambulance services and the essential drugs required for emergency response to reach certain locations.

The other factors borne of the government that caused the health workers not to accord to pregnant women maternal health rights included limited funding from government 19 (18.8%), lack of drugs and facilities 21 (20.8%) and poorly trained health care providers 5(4.9%). These results are similar to those earlier found by Miller et al, (2003) that

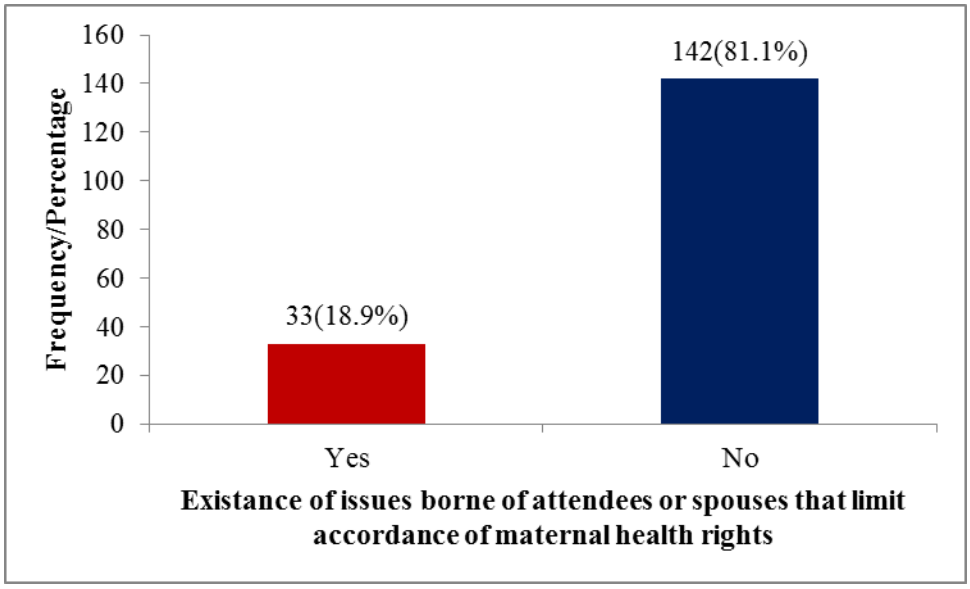
inadequate infrastructure, human resources and limited supplies as the other factors known to be inhibiting health to comply with maternal health rights. The results compare well with those earlier found by Shotton and Seedhouse (1998) that scarce resources was one of the factors that inhibited accordance of maternal health rights amongst the pregnant women.The current results however fail to compare well with those earlier found by Douglas and Douglas, (2004) that lack of privacy in the health facility was one of the central factors that lead to a loss of dignity inhibiting accordance of maternal health rights of the pregnant women. They are not in line with those earlier found by Seedhouse and Gallagher, (2002) who found that small bed spaces leading to the close proximity of beds as threatened dignity and therefore inhibited accordance of maternal health rights of the pregnant women. They are also different from those found by Rylance (1999) that physical structure of wards negatively impacted on patients' dignity in children's wards.

The implication of this finding is that during this research the government of South Sudan was experiencing several issues such as corruption, and administrative set up in the country where Juba County is a part, it is likely that government would lack the available fund to accord the rights to maternal health for pregnant women. It also meant that due to the presence of corruption there is likely hood there was limited or no drug to supply all the facilities studied in the County. This result also evidenced that as a result of limited funding there is also limited storage facilities the drugs that maybe available. This impedes the accordance of women rights to maternal health.

This finding also indicates that there is need for proper set up of monitoring and administrative systems to monitor the donor fund coming to support the County to promote health projects. It also means that government of South Sudan lacks proper funding to facilitate cool chain to keep the drug in certain facilities that are located in the rural places where there is limited or lack of power to keep the cool chain.

The pregnant women were also asked as to whether there existed some issues borne of pregnant women or their spouses that limits health workers from according women maternal health rights and the results were as presented in figure 2 below;

Figure 3: Existence of some issues borne of pregnant women or their spouses that limits health workers from according women maternal health rights



Source: Primary

The study results based on the majority of the respondent pregnant women showed that there existed some issues that make the health workers not to accord pregnant women maternal health rights 101(57.7%). The results in relation to the factors that caused the health workers not to accord to pregnant maternal health rights were as presented in table 4.5 below;

Table 4. 6: Factors borne of pregnant women or their spouses that limit health workers from according maternal health rights to pregnant women.

Factors borne of pregnant women or their spouses	Frequency (N = 33)	Percentage (%)
Cultural belief by mothers in law	7	21.2
Long distance	33	100.0
Lack of transport	19	57.6
restriction by our husbands	17	51.5
Too much home cores	5	15.2

Source: Primary

The study found the factors borne of pregnant women or their spouses that limited health workers from according maternal health rights to pregnant women as cultural belief by mothers in law 7 (21.2%). These results are different from those earlier found by Johnson (2005) that poor designs of the structures provided unacceptable privacy levels which much inhibited accordance of maternal health rights of the pregnant women. They are also different from those earlier found by Street and Love, (2005) that communal use of rooms inhibited accordance of maternal health rights amongst the pregnant women. The results similarly fail to compare well with those earlier found by the likes of Woogara, (2004) that single rooms offered greater privacy improving accordance of maternal health rights to women. The above result evidenced that as much as Juba County is the Capital City of South Sudan some women were still faced with the cultural that affect the accordance of maternal health as the culture may not allow them seek the healthcare during their pregnancy, at birth and after

delivery. This could be attributed to the fact that South Sudan being a new nation, the community is less educated and therefore still tied to cultural norms.

The results also show long distance 33 (100.0%) and lack of transport 19 (57.6%) as the factors they have limited according of maternal health rights. This could be attributed to the fact that the infrastructure is still undeveloped in most areas which is rural in nature. These result somewhat compare well with those earlier done by Thaddeus and Maine (2004) that lack of financial resources was a barrier to compliance of health workers with maternal health rights. The results are however different from those earlier found in a more recent study by Delayehu, (2013) that health workers' prejudice was the other factor that inhibited health workers from according maternal health rights to the pregnant women. The results compare well with those earlier found by Calnan et al., (2005) who found that shortages in staffing affected the dignity of the patients in a health care facility.

The other factors borne of pregnant women or their spouses was the restriction by their husbands 17 (51.5%) and too much home cores 5 (15.2%). These results fail to compare well with those earlier found by Matthews et al, (2010) that ruddiness, neglect, and abusive care was a limiting factor to the accordance of health rights in the urban facilities of Tanzania. The study results however compare well with those earlier found by Bowser and Hill (2010) that lack of autonomy and empowerment was factor inhibiting health to comply with maternal health rights. The results are also different from those earlier found by Jacelon, (2003) that sharing of bedrooms amongst patients which is different from what happens at homes resulted in the loss of privacy which inhibited women from securing their maternal rights appropriately. Restriction by husband meant the husband of those women were not aware about the rights of women to maternal health. It could also imply that these husbands might not have the basic requirement needed to send their women to health facility since during this research there was already ongoing war in the Country and part of Juba County was as well

affected, which equally affected the economic setup of these men. Another implication is that since South Sudan came from a long war and the men were still primitive and did not have experience about the benefit of their contribution to promote maternal health service, they do not know if it was necessary sending women for antenatal care. Meanwhile the finding on the home core meant that the studied community was still traditional community where every home core are done by women.

In support of the above challenges, the health care staff members during separate interviews said the following verbatim;

> "*We are few in this facility and…..some days you find you are alone….it may not be negligence but because we are few you find women are not receiving all that they require*" "*Sometimes the women come……..the medicines for emergency are not there. You find it hard to talk about rights…….most …..Witnessed maternal death. …. were caused by lack of emergency medicine since the places were distant from the medical facilities*". [I1]
> "*Talking of rights , there are …yet good legislation by government because of the turmoil unfolding to give them well to the women……the budget is low….drugs come late sometimes nothing, it is really hard*" [I7]

This finding compares well with Miller et al (2003) who find out that inadequate infrastructure and limited human resources affect utilization of health services. It also compares well with the work of Fathalla (2006) who found that lack of existence and enforcement of national law affect health services utilization. Looking at the above argument by the health staff it is obvious that these trained health staff do not have time to talk with the ANC attendant as they complained of being few at the facility level. Yet this is an element of the rights of women to receive detailed information about the benefit of maternal health. So the issue of being few is used as a factor of not being able to give detailed information to the ANC attendants. Even the occasional lack of medicines in the facility is a clear factor that inhibits accordance of the rights to maternal health for the women. This is evidenced by the fact that one of the health workers was reported to have said they give the required services except in the occasion where there are no medicines.

Contrary to the response of women about the issue of legislation is that the caregivers said there are legislation but attributing its understanding to the issue of insecurity. This is in line with the conceptual framework where enabling characteristics of the household behavior play a role in ensuring utilizations of health services. This implies that women who are attending could not know these legislation as a result of the conflict that could not allow the health officers make these women to understand. Insecurity create fears for both the health officers and women to get time and address policy concerns.

> "*No one to blame but the women themselves…..distance is far and culture makes them vulnerable to men who dictate on when or not to come for maternity services…they miss out on most of them and come almost when about to deliver ….they end up not receiving maternal health care…*""*….traditional behavior for relative to decide when a woman should be taken to the health facility remained very strong amongst the community. Due to the cost associated with purchase of basic items for delivery and payment of small administrative fees, family normally want to first sit and decide when a woman should be taken to a facility. Sometimes decisions are not reached until it is late and this resulting to a woman delivering at the hand of traditional birth attendants in which if there is a preexisting condition… So the traditional norms of denying a woman the rights to independently decide stops them from accessing the rights medication and which is a real human rights problem related to rights of women to maternal health..*" [*I*3]

The above argument of the different health personnel compares well with the conceptual framework of this study where the independent variable affect the dependent variables, in the accordance of rights to maternal health for the women. Disposing factors like the as culture, and enabling characteristics of distance travel are issues affecting the receipts of maternal health accordance. Issue of the long distance and cultural behaviors are seen to be factors that inhibits the accordance of the rights of women to maternal health. Long time spent in the travel to have the access to facilities affect accordance. Women find it difficult to cover the long distant to move to the facility that offer an ANC service. This finding compares well with earlier study done by Brigit et al (2012) who found the issue of culture and ethnicity affect accordance of utilization health services.

"*These women…..lack means to travel. I mean no transport for them to be able to reach. .....they say.,….husbands……..don't give them transport to reach here .and…sometimes their husbands I am told refuse them….*" [I4]
"…..number of staff are few and the women are many…..there is need for more staff if maternal health rights are to be properly given" [I2]

The above argument did not compare well with the earlier studies done by Dauglas and Douglas (2004) who fund that lack of privacy in the facilities inhibits the accordance of maternal health rights to the women. It also did not match well with Brinkerhoff (2003:7) who regarded inhabitance to maternal health accordance as a result of small bed leading to proximity in space threatening dignity. But this compares well with the conceptual framework on the disposing characteristics where cultural issues is a factor affect health service delivery.

"I can't tell but both the government and the women are the factors…..no drugs, few staff and insecurity makes it hard to provide ANC….the staff are sometimes poorly trained and husbands don't support their women….its both". "Women presence for delivery … is influenced by the attitude of the health care provider and the occurrences of safe delivery….if a given facility has history of unfriendly birth attendants it deters off women from attending ANC in the given place. The presence of medicine in a given facility influence the interest of women attending to a given facility. [I6]

The above finding is in line with earlier study by Shotton and Seedhouse (2000) who indicated that scarce resources as one of the factors inhibiting accordance of maternal health care to mothers. This did not compare well with the research of Woogora (2004) who established that delivery in a single room could offer great privacy in the accordance of maternal health. However in the conceptual framework, as indicated in the Anderson's behavioral theory, lack of drug and few staff are the element of enabling characteristics that assist the households in accessing maternal health services.

"The case in this poor funding from whoever gives us the facilities to be used. the hospital lacks drugs, how then can you give the women pregnant anti malarial which are not there….." ."…..women do not come to the facility because they felt the few trained health workers keeps embarrassing them and they get humiliated every time they need the help of health care officer". [I5]

These findings are quite similar to those earlier found by Miller (2003) who indicated lack of standards as an inhibiting factor. They are also similar to those by Fathalla, (2006) who found

lack of enforcement laws and policies coupled with disrespect and abuse are fundamental violations of ethical and human rights principles as the other factors that inhibit health facilities to comply with maternal health rights. The results were however different from those earlier found by Leape et al (2012) that lack of leadership and supervision for respectful maternity care was another factor inhibiting health to comply with health rights.

This study generally demonstrates good legislation by government but because of the turmoil unfolding, traditional norms of denying a woman the rights and the long distance as inhibiting maternal health rights accordance. The implication of the fact that legislations are in place, but still other factors as cultural issue being able to inhibit accordance of the rights of maternal health to women shows that this legislations are not being enforced so this legislations are there just to indicate to the international community that the nation is in compliance with human rights norms. Another meaning to this finding is that these policies and legislation about maternal health have not been made open to the women, they are not aware of the existence of the legislations as the finding indicated at one point that majority of women felt there is no proper legislation to monitor the compliance and as a result the lack of it inhibits accordance of their rights. But the response from the health workers differs in the sense that they denied the fact legislations never existed for them legislations existed showed negligent from the sides of the health workers to give awareness to the pregnant women about existence of policies and legislations and what they are set up for.

CHAPTER FIVE:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses the findings with respect to the objectives, makes conclusions based on the findings and makes recommendations for possible improvements with regard to the study on an investigation about the rights of women to maternal health, a case of Juba County.

5.1 Summary of findings

The current study found out that 46.9% of the pregnant women were highly knew about their right to healthcare before, during and after pregnancy and childbirth, 38.3% highly knew about their right to receive healthcare that is consistent with current scientific evidence, and 46.3% highly knew about their right to choose a midwife or physician as their maternity care provider.

The study also found 34.3% of the pregnant women highly knowledgeable about their right to information about the professional identity and qualification of those involved with the health care, 32.6% highly knowledgeable about their right to communicate with their caregivers and receive all care in privacy and 46.3% highly knowledgeable about their right to full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments.

This study also established that 40% of the pregnant women were highly knowledgeable about their right to freedom of movement during labor, 45.7% of them highly knowledgeable about their right to be informed if their caregivers wished to enroll them or their infants in a research study and 46.9% knowledgeable about their right to decide collaboratively with caregivers when receiving ANC.

The current study however found 38.9% of the pregnant women not knowledgeable about their right to receive continuous social, emotional and physical support as a maternal health right, 44.6% of them not knowledgeable about their right to receive complete information about the benefits of breastfeeding, and 46.3% of them not knowledgeable about their right to leave their maternity care giver and select another if they became dissatisfied with her care. It also found 56.6% of the pregnant women not knowledgeable about their right to receive maternity care that is appropriate to their cultural and religious background.

The current study established that 33.7% of the pregnant women did not know of their right to have family members and friends of their choice present when attending as opposed to 61.7% of the pregnant women who did not know of their right to accept or refuse procedures, drugs, tests and treatments. The current study generally found a low level of knowledge about maternal health rights among pregnant women attending ANC services (Mean = 2.92, S.D = 1.26). Generally the implication to this finding is that women have limited knowledge about the rights to most of the basic rights since from the character of the community is that majority of them are in their second or third birth so they had previous experience so the knowledge is generally limited as indicated by the standard deviation. This limited knowledge is owing to the information they get from other women who visit the health centers and other health officials.

The current study established up to 35.3% of the pregnant women often accessed healthcare whenever they visited to the health facility, 40.6% of them often communicated with their caregivers and received all care in privacy and 38.9% of them often received complete information about the benefits of ANC services as compared to 38.9% of them who often received maternity care that identified and addressed social and behavioral factors that affected women health and that of their babies.

This study however established 43.4% of the pregnant women rarely chose a midwife or physician as their maternity care provider with an equal proportion rarely receiving full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments.

Overall the meaning to this finding is that due to limited skilled staff, lack of knowledge to choose healthcare providers, insecurity and limited or no drugs in part of the Juba County contribute to limited compliance with the rights of women to maternal health. More so, due to the limited number of the trained health personnel, the few staff finds it hard to give a complete information to the pregnant women seeking the ANC service making it hard for this women to understand the benefits of the ANC.

This current study similarly found a low compliance with maternal health rights by health workers among pregnant women attending ANC in Juba County (Mean = 2.91, S.D = 1.28).

This current study found that the factors borne of government that inhibited the health staff from according the pregnant women maternal health rights as few health staff (4.9%), improper legislation supporting health care services (21.8%) and insecurity which rendered access to the health care hard (29.7%). The other factors borne of the government that caused the health workers not to accord to pregnant maternal health rights is limited funding from government 19 (18.8%), lack of drugs and facilities 21 (20.8%) and poorly trained health care providers 5(4.9%).

The current study found the factors borne of pregnant women or their spouses that limited health workers from according maternal health rights to pregnant women as cultural belief by mothers in law (21.2%), long distance (100.0%) and lack of transport (57.6%). The study found the other factors borne of pregnant women or their spouses as restriction by their husbands 17 (51.5%) and too much home cores 5 (15.2%).

Implication to this was established that since Juba County is located in South Sudan, the general meaning is that the community is not developed and health issues are not align to the cultural norm so the community understanding of the culture takes upper side as compared to understanding of maternal health procedures. Also it is true that limited funding is another factor inhibiting compliance accordance to maternal health since there is no proper funding to the facilities. Funding issue would have also be made worst by the corruption in the new state making the proper accordance of the rights to maternal health literally impossible.

5.2 Conclusions

There is generally less knowledge on part of the mothers in as far as the maternal rights are concerned. This could be mainly because of the less education and sensitization among the population on the need for better maternal health which the women have to be offered. Such low knowledge may also be attributed to the cultural beliefs that surround the communities where the women come from areas where the knowledge is lacking such as the need to have social and emotional support during maternity, there is need to educate the ANC seekers, the pregnant women so that they are able to understand such rights. More so, to acquire the best knowledge about the rights of women to maternal health, there is need to impact information on these rights and these rights must be listed categorically so that they are aware of the rights related to maternal health. Central in getting knowledge to maternal health is the benefit of the information and the ideas to know how to collaborate with the health care givers since during the collaboration women would be allowed to asked more questions it is from the questions they will get to know their rights.

The women are rarely accorded maternal health human rights. This is a result that there is limited health care givers who are trained enough to spare their time to have the rights accorded to this as required by the health legislation. Also this could be attributed to limited

advocacy by the organizations in charge or to none existence of organizations whose mandate is aimed at according maternal rights to the women of reproductive age. In all government need to train more health personnel, who are always compliant with the rules and regulation related to accordance of these rights.

Government concerted efforts towards improving maternal health remains far from reaching optimal. This could be attributed to the insecurity issues that surround the country amidst the need to ensure rights to be accorded in maternal health.

As indicated in the age bracket earlier there are some issues related to early marriage which could lead to sepsis which is caused by Female Genital Mutilation which is a cause of many maternal deaths in the county. The reasons given for the practice of Female Genital Mutilation to avoid promiscuity amongst women but this practice is responsible for potential dangers as hemorrhage and maternal health infections. The practice of which is an evidence to factors inhibiting the rights of women maternal health. It is a popular saying that health is wealth and a healthy nation is a wealthy nation since in community like that of Juba County, women play key role in the provision of food for the family any maternal health related issue could be a blow to the community. Thus, maternal health is an issue of central concern to South Sudan though Juba County has some slight exception and societies in it is a crucial cornerstone for socio-economic development and progress. This explain the need for the promotion and protection of the rights to maternal health to have a healthier society.

Comprehensive maternal health education programs must be implemented in the County, communities and upper primary school who are able to understand the concept of rights to maternal health.Comprehensive rights to maternal health should not be mixed with biological education so girls should be taught in school about their rights to health as a fundamental human rights and what does their health means to them if messed up. This kind of education will only impact the knowledge about the rights to maternal health but avoid the issue of

early marriage as the community of the County will know the effect of poor health or early marriage could cause death. This education should also involve the usage of contraceptive and communication about decision making in both the use of the contraceptive as well as early pregnancy. It would help them learn how to establish equality in relationships as part of their human rights, respect the right to consent in both early sex and early marriage, and end violence and sexual coercion. Men at both the County and community level should play a key role in bringing about gender equality, thus, it is imperative to educate men on the need for rights to maternal health for the Juba County and community. This will play essential role to improve communication between men and women on issues of rights to maternal health, and the understanding of their joint responsibilities, so that men and women are equal partners in providing the compliance as well as knowledge to maternal health.

Government should take positive steps to implement the existing laws and treaties on women's rights in line with the suggestions made earlier. It is imperative to domesticate CEDAW in South Sudan law and the county must adapt it to law. Laws that are discriminatory against women should be amended or repealed as the case of those discrimatory norms and must be in line with international human rights standards. The National Assembly and the State Assemblies must enact laws prohibiting violence against women as a matter of urgency. This would further increase access to health rights. Most importantly, the 1999 Constitution must be amended to make socioeconomic rights justifiable.

The health care staff members who are either less concerned about the issue of according maternal health rights to the pregnant mothers needs to be trained to adjust to an acceptable human rights standards related to maternal health. This is reflected by the fact that mothers are not allowed to choose health worker attributed to the fact that there are few health workers or much load among others. To be incompliant with the rights to maternal health

government or the organization concerned about the women's rights to maternal health to offer the element of accessibility of the health care services to the mothers so that they have the services required both in the rural and urban areas to avoid the long distance taken by the mother in the process of getting the required maternal health services required during pregnancy, at birth and after birth. The restriction from the part of the spouse and the relatives of the in-laws contribute to poor accordance of maternal health rights. This issues need to be addressed by the government entity or grass root organization through giving out information about the importance of accessing maternal health rights.

The factors inhibiting compliance such as the home cores that women have, the restriction by husbands, the long distance travelled and cultural belief all together requires sensitization to the community in order for them to understand the benefit related to the accordance of the rights of women to maternal health. This sensitization should not be done by health personnel only, community leadership need to be involve in this process and should involve the use of monitoring intervention. Community leadership should take the responsibilities in leading the monitoring intervention so as the community is incompliance with the health policy related to the rights of maternal health.

Generally the practice of promoting rights to maternal health in Juba County in particular and South Sudan at large is still below internationally acceptable standards and government is doing minimal as the current ongoing war in South Sudan cannot allow even its improvement but creating even worst as resources are depleting on day to day basis due to the ongoing war in the country. Achieving MDG 5 in Juba County clearly requires that all women and men have ready access to maternal health education and contraceptive choices that are affordable and acceptable through services that are readily available and based on confidentiality and informed consent. Promoting Rights to maternal health are major components of reducing maternal mortality and morbidity in Juba County to promote the rights to maternal health

which is an inalienable right of the woman. When women have access to good information and health care, they are in a position to make sensible choices about marriage and the size of their family they intend to have. Limitation to rights to information has created even worst. Such individual decisions to have a better family size can add up to better lives for women of Juba County and their families, and, ultimately a better knowledge to the rights to maternal health. When young people are able to get maternal health information and services, they increase their chances to make a successful transition to adulthood since the reproductive age is regarded as the most dangerous period due to in a woman's life in Sub Sahara Africa as a result of maternal mortality. Saving women's lives requires a functioning health system to deliver the package of sexual and reproductive health services. Health system investments in women's sexual and reproductive health services provide a strong foundation for health services for all. With accessibility to comprehensive maternal health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life.

5.3 Recommendations

There is need to increase advocacy in as far as maternal health rights are concerned. This should target the women of reproductive age. In fact efforts should be geared towards increasing their knowledge on the maternal health rights and as well encouraging them to demand for accordance of the maternal health rights.

There is also need to integrate maternal health rights with the cultural beliefs embedded within the community members. This will permit autonomy amongst the women that is supported by the men given that maternal health rights will be coherent with known cultural practices borne of the community. The County has some cultural issue that prevent the women from accessing the antenatal services required of them. So integrating the cultural

normal in accordance to maternal health service will improve the understanding of the community to maternal health.

The health workers need to be educated about the maternal health rights and how best they can accord them to the women of reproductive age amidst prevailing health system challenges. This calls for concerted efforts that are both led by the civil society and the local community leaders. In fact the rights to maternal health need to be introducing to the health workers as a subject detailing all the element of the rights to maternal health. Also ethical consideration must cut across element of the rights to maternal health, so that once the health workers violated these rights it will be an ethical issue that is punishable by law and this should be enforced to the national law to allow health workers to strictly observe such ethic and adhered by it.

In promoting the rights to maternal health, women need to be trained in the birth preparedness and readiness. From the finding it appears that woman are not prepared enough when they are closed to the time of giving birth but promoting the rights to maternal health means health workers should prepare the women of what is needed from them when they are about to give birth, at birth and after birth. This preparation must not only cover the birth planning but readiness for issues related to complication amongst others. The birth preparedness and readiness must cover the facility the woman is expected to give birth, the nurse in charge and items expected of her. This makes the family of the pregnant women prepared earlier enough of all the necessary health demand. Birth preparedness and complication address to increase knowledge of women in the County. This birth preparedness and complication address be delivered to the community by the health officials and also civil society organizations. This package should include amongst others the desired place of the facility; the preferred birth skilled birth attendant; the location of the closest facility for birth and in case of a complication; funds for any expenses related to birth and other supplies and

materials necessary to bring to the facility; an identified labor and birth companion; an identified support to look after the home and other children while the woman is away; transport to a facility for birth or in the case of a complication. This is package is important as evidenced in the research carried out by Solnes Miltenburg et al (2015) in Tanzania.

Male involvement intervention is another recommendation the study provides. Male involvement as a partner, husband and community member plays important role in the provision of maternal health services. As evidence in the finding shows the role men play is vital, their involvement in the whole process of maternal health services is crucial. Firstly once they are able to understand the importance of provision of maternal health services, they are able to provide the required items needed to help the pregnant women during antenatal care, at birth and after delivery. Also as it is indicated in the finding that men sometime avoid their women from visiting the antenatal services, their involvement would help them to understand and avoid such traditional behavior. The recommendation of involvement of men in to antenatal care process is so that they are aware of the rights to maternal health. Once men are aware, they do not prevent their woman from going to the medical facility to access health services during pregnancy. Involvement of man in the right based care enables the men to respect, promote, and facilitate women choices in self-autonomy, in decision making and in regards to their health during the pregnancy and at birth. During this time, women have also the rights to be assisted in taking care of themselves so men will play vital role once they are made aware of what is expected of them.

Juba County government should introduce Community organize transport scheme to help transport pregnant women to the health facilities. As one of the factors inhibiting the compliance of the health is the issue related to transportation of the pregnant women to the health facilities, the county officials should introduce the community sponsored transport means to help the pregnant women reach the nearest health facility to access antenatal

services when required. This means of transport will help the women access the facilities in case of any complication.

Maternity waiting homes for the pregnant women to be kept close to the health facilities

Juba County health officials should consider partnership with the traditional birth attendance. This arrangement of the partnership should be accompanied the design and monitoring of important processes of implementation in order to be able to understand the effect of the different modes of delivering the intervention and also train the traditional birth attendance in handling some minor complications during and after birth. Also the health official should introduce for the County and the nations the Standardization of some outcome measures allowing for the possibility of local contextualization.

Juba County during the finding of this research identified cultural issue as one element inhibiting the rights to compliance with the maternal health. So as a recommendation providing culturally appropriate skilled maternity care is one core areas that needs to be implemented to ensure that the health care services is not in conflict with the maternity services. This might take the form of health official having a continuous dialogue with the community leaders

At the national level the state line ministries should include a separate budget to promote the rights to maternal health. If this budget exist, there is need to setup a clear monitoring strategies to make sure that this money is used as required. This budget must have a set monitoring strategies to ensure that it is used for the purposes of implementing maternal health in Juba County as well as that of South Sudan at large to ensure that there is proper information and maternal health education is done both at facility level, nursing school and the community in South Sudan at large. In other rural community this budget will be used to facilitate some free maternal care services to those in need of those services but could not afford to have it due to lack of fund.

All in all there is need for additional research that should cover regional and state wide locations to give a notable recommendation because for this research to add value in policy decisions, a wider coverage of research needs to be adapted to enable policy makers to adapt this research in their decision making. Additional research will also improve the quality of evidence that will also be used for international and non-governmental organizations to help adapt it into their policies.

5.4 Areas of further research

The findings of the current study are based on only information from 175 pregnant women and the 10 health workers. The results thus may not hold much policy implication as of now given that they would vary if a larger sample and more pregnant women were to be involved. It's therefore recommended that further studies be carried out considering this limitation for a more optimal intervention.

This study only examines maternal health considering pregnant mothers that were attending ANC services. It leaves out the views of those that are giving birth and those in the post-partum period. It is thus recommended that further research consider these two groups for a more optimal intervention.

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APPENDICIES

Appendix I: Questionnaire for the pregnant women attending ANC in juba county hospitals

Dear respondent, my name is Koma Henry Okomi, undertaking a study to "**An investigation on the rights of women to maternal health; a case study of Juba county**". This research is purely for academic purposes and all the responses given will be treated with utmost confidentiality. Please take time to answer these few questions by ticking the appropriate options. Thank you for your cooperation in advance.

A: Demographic characteristics

1. Age in years (a) 15 – 25 (….) (b) 26 – 35(….) (c) 36 and above (….)

2. Marital Status (a) Single (….) (b) Married (….) (c) Widow (….)

3. Education Level (a) None (….) (b) Primary (….) (c) Secondary (….) (d) Tertiary (….)

4. Trimester (a) First Trimester (….) (b) Second Trimester (….) (c) Third Trimester (….)

5. Number of times of attending ANC clinic_____

6. Parity_____

B: Knowledge about maternal health rights

On a scale of 1 to 5 where 1- Strongly Disagree (S.D), 2-Disagree (D), 3- Not Sure (N.S), 4 – Agree and 5- Strongly Agree (S.A), tick the most appropriate maternal health rights that are known to you.

Maternal health rights	**Strongly disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
I have a right to healthcare before, during and after pregnancy and childbirth					
I a right to receive healthcare that is consistent with current scientific evidence					
I have a right to choose a midwife or physician as my maternity care provider					
I have a right to receive complete information about the benefits of breastfeeding					
I have a right leave my maternity care giver and select another if I become dissatisfied with her care					
I have a right to information about the professional identity and qualification of those involved with my care					
I have a right to communicate with my caregiver and receive all care in privacy					
I have a right to full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments					
I have a right to accept or refuse procedures, drugs, tests and treatments					
I have a right to receive maternity care that is appropriate to my cultural and religious background					
I have a right to have family members and friends of my choice present when attending ANC					
I have a right to freedom of movement during labor					
I have a right to decide collaboratively with caregivers when receiving ANC services					
I have a right to receive continuous social, emotional and physical support					
I have a right to be informed if my caregivers wish to enroll me or my infant in a research study					

C: Compliance with maternal health rights

Please on a scale of 1 to 5 where 1- Never, 2-Rarely , 3- Sometimes, 4 – Often and 5- Always, indicate the extent to which the health care staff accords to you the maternal health rights when attending ANC in this health facility by ticking the most appropriate

Compliance	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
I receive complete information about the benefits of ANC services					
I access healthcare whenever I come to this health facility					
I choose a midwife or physician as my maternity care provider					
I communicate with my caregiver and receive all care in privacy					
I receive full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments					
I receive maternity care that identifies and addresses social and behavioral factors that affect my health and that my baby.					

D: Factors inhibiting compliance with maternal health rights of the pregnant women among ANC health care staff

In your view based on your experience while visiting this health facility for ANC services, do you think there are some issues that make the health workers not to accord you your maternal health rights? (a) Yes (….) (b) No (….)

If yes in the question above what causes the health workers not to accord to you your maternal health rights?_____

Do you think there are some issues borne of you yourself or spouse that limits health workers from according you your maternal health rights? (a) Yes (….) (b) No (….)

If yes in the question above what issues that are borne of you or your spouse that limit health workers from according maternal health rights to you?_____

In your own view what do you think can be done to improve compliance by health staff with maternal health rights of the pregnant women in Juba county hospitals?_____

_____

_____

Thanks for your cooperation

Appendix II: Interview guide for the health care staff

1. Are you acquainted with the maternal health rights of the women? If yes which ones are you acquainted with? Explain you answer with examples
2. Please for the time you have worked here, do you think the pregnant women are knowledgeable about their maternal health rights? If yes to what extent do you think they are knowledgeable?
3. Which maternal health rights do you think women know? Why these maternal health rights
4. As health staff in this health facility, to what extent do you accord maternal health rights to the pregnant women attending ANC? Please give details
5. Which maternal health rights are the pregnant women most accorded with by you as maternal health care staff? Provide details to your answer
6. Please which factors borne of the government render you not to accord some maternal health rights to the women?
7. Are there any factors borne of the women and their spouse that limit women from being accorded maternal health rights? If yes which ones
8. In your own view, what do you think can be done to ensure successful upholding of maternal health rights to the women?

Thanks for your precious time.