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Assessment of the Level of Knowledge of Respectful Maternity Care and Sexual and Reproductive Health and Rights in South Sudan

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Abstract **Background:** Despite a noticeable decrease over the past ten years, South Sudan still ranks among the countries with the highest maternal and neonatal mortality ratios in the world. The provision of a care that is more client-centered and culturally sensitive, such as Respectful Maternity Care (RMC) in a Sexual and Reproductive Health and Rights (SRHR) enabling environment, is key to reducing maternal and neonatal mortality. Nevertheless, health care providers' and consumers' perceptions, awareness and level of knowledge may influence the uptake and potential impact of RMC. **Objectives:** To assess 1) the level of understanding of RMC and related clinical practices among health care providers, as well as gaps in knowledge and skills for the uptake of RMC at targeted health facilities in the project regions ("What midwives want"); 2) the level of understanding of RMC and SRHR among women of reproductive age (including adolescent girls and women with disabilities), as well as women's current experiences of care, unmet needs, and preferences at targeted health facilities in the project regions ("What women want"); and 3) the level of understanding of RMC and SRHR among key stakeholders (health facility administrators, male community members, youth representatives) as well as their views and perceptions of women's SRHR in targeted communities within the project regions. **Methods:** Using mixed methods, data were collected from health facilities in six states in South Sudan. Quantitative data were analyzed using Microsoft Excel 2010. Some qualitative data were analyzed by grouping them according to the domains of RMC or the domains of SRHR as based on the established literature, while other qualitative data were analyzed by coding and identifying categories and themes within the data. **Results:** Only 5% of key stakeholders and <1% of women of reproductive age correctly listed three examples of SRHR. Seventy percent of key stakeholders reported that RMC was a commonly used terminology. However, more health care providers than women of reproductive age had heard about RMC either occasionally or often, while more women of reproductive age (43%) than health care providers (8%) had never heard about RMC. When asked to identify key elements of RMC, 53% of health care providers compared to 45% of key stakeholders and 31% of women of reproductive age gave an answer that aligned with one or more of the 12 domains of RMC. The most cited type of support that health care providers required in order to provide RMC was both general and RMC-focused capacity building, followed by increased salaries and other forms of motivation as well as ensuring supplies and equipment are made available. The proportion of women of reproductive age who reported sometimes or never receiving RMC was generally higher than the proportion of health care providers who reported sometimes or never rendering RMC, suggesting a misalignment between the perceptions or reporting practices of these two groups. Similarly, more women of reproductive age reported incidents of mistreatment than did the health care providers. **Conclusion:** There is a limited understanding of RMC and SRHR among health care providers, key stakeholders, and women of reproductive age. It is recommended that the Ministry of Health, together with implementing partners, organize and conduct RMC and SRHR awareness activities that target service providers, service consumers, and key stakeholders in order to sensitize them to the rights of childbearing women and newborns.

Keywords: *respectful maternity care, sexual and reproductive health and rights, maternal health, health care providers, midwifery, women of reproductive age*

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1. Introduction

Although there has been a noticeable decrease in maternal mortality, from 2,054 maternal deaths per 100,000 live births in 2012 [1] to 1,150 maternal deaths per 100,000 live births in 2017 [2,3], South Sudan still ranks among the countries with the highest mortality ratio in the world. Measures such as training and deployment of health care providers as well as promotion of health facility births are currently being implemented in South Sudan in order to reduce maternal and neonatal mortality. However, recent research findings indicate that increasing health facility births alone does not necessarily reduce maternal and neonatal mortality [4,5,6]. Emphasis is being put on the provision of a care that is more client centered and culturally sensitive [7]. One rights-based approach to providing this type of care is Respectful Maternity Care (RMC), which is defined as "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth" [8]. Furthermore, the promotion of RMC by competent health care providers is likely to enhance the sexual and reproductive health and rights (SRHR) enabling environment, as well as maternal health outcomes in South Sudan [9]. Nevertheless, health care providers' and consumers' perceptions, awareness and level of knowledge may influence the uptake and potential impact of RMC. There was therefore a need to assess the level of knowledge of RMC and SRHR among health care providers, women of reproductive age and community stakeholders at targeted health facilities in South Sudan.

2. Methods

This was a cross-sectional study using mixed methods. The population consisted of health care providers, women of reproductive age including women with disabilities, as well as key stakeholders such as health facility administrators, hospital or county directors, male community members, and youth and women representatives.

Both qualitative and quantitative data were collected from six states. These states were selected on the basis of those targeted by the SMART-RMC project (Northern Bahr el Ghazal, Unity, and Western Equatoria), as well as an additional set of states (Eastern Equatoria, Lakes, and Western Bahr el Ghazal) to ensure a nationally-representative reach of the survey across South Sudan's three regions. One or more health facilities were selected from one county in five of these states, while one or more health facilities were selected from two counties in one of these states.

The facility inclusion criteria included accessibility, provision of skilled antenatal care (ANC) and maternity services, and being staffed with at least one midwife (or nurse). Health care providers and administrators included those working at the selected facilities, while women of reproductive age included those who had ever received care from the selected facility.

At each health facility, sampling strategies included convenience and purposive sampling as appropriate to address qualitative and quantitative research questions.

Following ethical approval from the Ministry of Health, data were collected through face-to-face interviews and focus group discussions. Therefore, study tools included an unstructured interview guide to gather qualitative data as well as a questionnaire and checklist to collect quantitative data. Where appropriate and with permission from participants, interviews were audio-taped and transcribed verbatim. Qualitative data were collected until no new information was forthcoming (data saturation).

All possible identifiers were removed from the collected data. For example, data were transcribed without identifiers and only exemplars from these transcripts were shared when reporting the findings. Some qualitative data points were analyzed by grouping them according to the 12 domains of RMC [10] or the domains of SRHR [11] (as based on the established literature), while other qualitative data points were analyzed by coding and identifying categories and themes within the data, through a process of thematic analysis. Quantitative data were entered into and analyzed using Microsoft Excel 2010. Results are presented in the form of text, tables, and figures as appropriate.

3. Results

All data were collected between August 8 and September 27, 2022. Data from health care providers were collected from 122 respondents, of whom 55 (45%) were females, in 18 health facilities, six counties, and six states. Respondents also included 78 key stakeholders, of whom 32 (41%) were females, and 211 women of reproductive age, all from seven counties in the same six states. Furthermore, three focus group discussions were conducted within three health facilities in one county. The groups had, respectively, 1) 11 members of whom 4 were females, 2) 9 members of whom 5 were females, and 3) 8 members of whom 3 were females.

Among the 122 health care providers, there were 12 clinical officers, 6 medical doctors, 58 midwives (all categories combined), 34 nurses (all categories combined), and 12 others. The shortest serving health care provider had served for 4 months while the longest serving had served for 34 years. The average length of service was 6 years. Among the 78 key stakeholders, there were 15 health facility administrators, 4 hospital or county directors, 6 matrons, 11 unit in-charges, 20 youth representatives, 3 nurses, 2 midwives, 3 husbands, 2 housewives, 2 monitoring and evaluation officers, 2 women leaders, 1 government official, 1 Inspector General, 1 Civil Society Organization representative, 1 clinical medicine student, and 4 others (title not specified).

Among the 211 women of reproductive age sampled, 5 had a disability. The youngest woman was 15 years old while the oldest was 47 years old. The average age was 26 years while most frequent age among respondents was 20 years. Among the 210 women of reproductive age whose occupation was indicated, there were 130 housewives or domestic workers, 16 farmers or garden workers, 16 students, 13 health workers, 12 foodstuff sellers or restaurant workers, 11 businesswomen or self-employed

individuals, 7 teachers, 4 cleaners, and 1 data clerk. Furthermore, among the 210 women whose gestational status was reported, there were 32 teenagers who had ever been pregnant, and among these, one who had been pregnant once by age 15, one who had been pregnant three times by age 16, and 2 who had been pregnant three times by age 19. In the larger group, eight of the women had been pregnant 8 times, 6 had been pregnant 9 times, and 1 had been pregnant 11 times. One had never been pregnant by age 30. Five of the women had never attended ANC for any of their pregnancies, one of them having been pregnant 8 times and another 6 times. Three other women had attended ANC for some but not all of their pregnancies. Forty-five women had given birth at home at least once, including 6 of the 43 women who had given birth once, 7 of the 35 women who had given birth twice, as well as 6 of the 32 women who had given birth thrice. One woman had given birth at home for all of her 7 children, another for all 8, and another for all 9.

Key stakeholders and women of reproductive age were asked to list three examples of SRHR. Out of the 78 key stakeholders, only 5%, (1 female and 3 males) correctly answered the question, compared to only 1 out of 211 or <1% of women of reproductive age. Only 12% of key stakeholders (3 females and 6 males) and 9% of women of reproductive age correctly provided 2 examples, while 49% of key stakeholders (18 females and 20 males) and 42% of women of reproductive age correctly provided one example. While 6% of key stakeholders (of which 2 females) and 35% of women of reproductive age acknowledged not knowing any example of SRHR, 28% of key stakeholders and 15% of women of reproductive age gave one or more answers that were not specific to SRHR. One of the five women of reproductive age with disability correctly provided one example. Collectively, one of the three focus groups could correctly state two examples, one other group one example, while the other group stated answers that were not specific to SRHR. Accepted answers for examples of SRHR are presented in Annexure 1.

The majority of key stakeholders, or 70% (n = 74), reported that Respectful Maternity Care (RMC) was a commonly used terminology. However, none of the 5 women of reproductive age with disability had ever heard about RMC. It also transpired from all three focus group discussions that RMC was not a common terminology. As presented in Figure 1, more health care providers than women of reproductive age had heard about RMC either occasionally or often, while more women of reproductive age (43%) than health care providers (8%) had never heard about RMC.

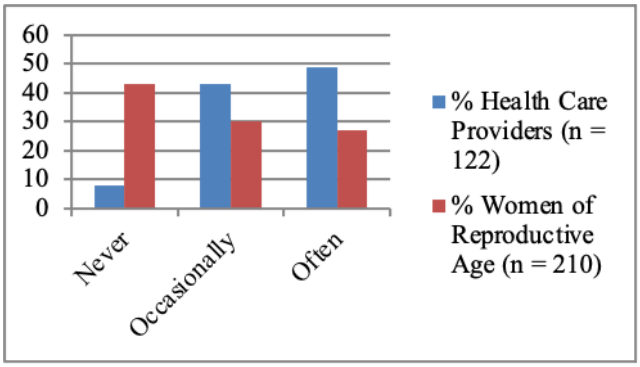

Figure 1. How often RMC is heard among Health Care Providers compared to Women of Reproductive Age

All respondents were asked what RMC meant to them. Just above half, or 53% (n = 122) of health care providers compared to 45% (n = 78) of key stakeholders and 31% (n = 208) of women of reproductive age gave an answer that aligned with one or more of the 12 domains of RMC. The remaining either gave an answer that was not specific to RMC or stated that they did not know. Three out of the five women of reproductive age with disability stated that they did not know what RMC meant while the other two stated answers that were not specific to RMC. One of the three focus groups could not state any answer specific to RMC while the other two focus groups gave an answer that aligned with two of the 12 domains of RMC. As presented in Table 1, preserving women's dignity was the most cited domain, mentioned by 23% of health care providers, 18% of key stakeholders, and 19% of women of reproductive age. Other frequently cited domains (mostly by health care providers and key stakeholders) were respecting women's choices, maintaining privacy and confidentiality, and ensuring continuity of care.

Table 1. The meaning of Respectful Maternity Care to respondents (proportion of each group citing individual domains of RMC)

	% of Health Care Providers (n = 122)	% of Key Stakeholders (n = 78)	% of Women of Reproductive Age (n = 208)	% of Total (n = 408)
Preserving women's dignity	23	18	19	20
Respecting women's choices that strengthen their capabilities to give birth	16	6	0	6
Maintaining privacy and confidentiality	8	10	3	6
Continuity of care	10	6	3	6
Being free from harm and mistreatment	6	3	1	3
Prospective provision of information and seeking informed consent	2	1	3	3
Availability of competent and motivated human resources	1	4	2	2
Providing equitable maternity care	2	1	1	1
Enhancing quality of physical environment and resources	0	1	1	1
Ensuring continuous access to family and community support	2	0	0	1
Provision of efficient and effective care	0	3	0	0
Engaging with effective communication	0	1	0	0
Don't know / Answer not specific to RMC	47	55	69	60

Although just above half of the 122 health care providers who responded could cite one or more domains of RMC, the majority of them, including those who could not cite any domain of RMC, indicated that they were very confident (37% of respondents) or confident (38% of respondents) in providing RMC. Two percent of the respondents indicated that they were neutral, 19% somewhat confident, and 5% not confident in providing RMC.

When health care providers, key stakeholders, and women of reproductive age were asked about the support that health care providers required to provide RMC, the most cited was the need for capacity building in general and on RMC in particular, followed by the need for increased salaries and other forms of motivation as well as ensuring supplies and equipment are made available. Other cited needs were a conducive working physical environment, increasing the number of health care providers, and availing guidelines on RMC. Heavy workloads and limited supplies and equipment were also cited as key barriers in the three focus group discussions. However, when asked about gaps in providing RMC, non-conducive physical environments such as lack of lighting equipment at night and limited room space, limited supplies and equipment, as well as limited number of personnel on duty (leading to work overload and delays in provision of care) topped the list. Other cited gaps included limited knowledge among health care providers regarding RMC, low salaries, and lack of motivation.

On the physical condition of health facilities, respondents commented that facilities had limited space in terms of size and number of rooms, and were lacking lights, latrines, water supplies, placenta pits, beds and mattresses, and rooms for sick staff members in addition to general cleanliness. The following are extracts from respondents' statements:

(It) is not perfect, it needs more space for privacy of the patient and protection not enough rooms

This facility needs more rooms especially large rooms for maternity clients

Not enough space, very small building, no fence, no privacy

Some rooms are leaking like maternity, no light in maternity, no running water

The facility has a better maternity, few latrines, inadequate water supply and few rooms

All building needs renovation, no conference hall, not staff ward, no staff pharmacy

Lack of room for sick staff

Patients share beds, latrine is full and the environment is not conducive

The rooms are clean but the surrounding is dirty

Rooms and toilets are dirty

However, as reflected in the following extracts, some respondents were satisfied with the physical condition of their health facilities:

The facility is very good, nice building and adequate rooms and space

The facility is nice, clean, well arranged with full equipment, beds and good ventilation

It is well constructed, with enough ventilation, light, water

Respondents further commented that staff members were few, required trainings to keep their knowledge updated, and needed to be paid and motivated. These sentiments are reflected in the following extracts:

(This) facility has low staffing, it needs more qualified midwives and nurses

Too old staff, poor and outdated knowledge of the staff

We need trained health workers to provide quality services to all the mothers and even all people

Poorly motivated staff, poor skills, heavily loaded, lack of training

The staff need to be paid well and on time

Nevertheless, some women of reproductive age reported that they were satisfied with the care received from health care providers, though there may be room for improvement. This is noted in the following extracts:

The staff are good let God bless (them) to continue working for us here

They are doing well and cooperate

The staff are friendly for me taking care, greeting and respecting clients always

Some staff are good others do not communicate well

For certain respondents, some facilities had enough staff but some needed training on RMC, as captured in the following extracts:

The number of staff is enough and all qualified

Enough staff but limited knowledge on RMC

Sixty-two percent of health care providers compared to 58% of key stakeholders stated that there were not sufficient rooms in health facilities to ensure privacy, while for 50% of women of reproductive age, the space was sufficient.

Fifteen percent of key stakeholders reported that there had been incidents where health care providers treated women in a non-pleasing or inadequate manner, such as insulting them, failing to ensure privacy, or not having the necessary supplies or equipment in the facility.

Table 2. The meaning of Sexual and Reproductive Health and Rights to respondents (proportion of each group citing individual elements of SRHR)

	% of Health Care Providers (n = 122)	% of Key Stakeholders (n = 78)	% of Women of Reproductive Age (n = 200)
Fertility control	16	14	28
Equitable services to all	25	8	10
Access to contraception	3	6	0
Prevention of GBV	1	0	0
Safe abortion services	0	0	0
Negative attitude change	0	0	0
Non-specific to SRHR/Don't know	60	72	64

The most cited challenges were the limited number of staff to render maternity services as well as low or no motivation among the few available staff members. Suggestions from respondents on what could be done in order to promote the provision of RMC included increasing the number of staff, increasing salaries, having refresher courses for health care providers, improving the physical working environment in terms of space and number of rooms, and ensuring the availability of necessary supplies and equipment.

All respondents were asked what SRHR meant to them. As presented in Table 2, the majority of respondents, or 60% (n = 122) of health care providers, 72% (n = 78) of key stakeholders, and 64% (n = 200) of women of reproductive age, gave an answer that was not specific to SRHR or stated that they did not know. Only two domains of SRHR, namely fertility control and providing equitable services to all, were cited by some respondents among health care providers, key stakeholders, and women of reproductive age. Access to contraceptives was cited by some health care providers and key stakeholders only, while prevention of gender-based violence was cited by only one health care provider. None of the respondents cited access to safe abortion services or changing health care providers' negative attitudes towards SRHR. One of the three focus groups was able to cite two domains of SRHR while the other two groups each cited one domain.

On the one hand, as presented in Figure 2, the proportion of women of reproductive age who reported always receiving RMC was lower compared to that of health care providers who reported always rendering RMC. For example, while more than 90% of health care providers reported that they always ensured privacy, explained procedures, provided information on findings, greeted their clients, and maintained confidentiality, the proportion of women of reproductive age who always received this care ranged from 71% to 77%. On the other hand, as presented in Figures 3 and 4, the proportion of women of reproductive age who reported sometimes or never receiving RMC was generally higher than the proportion of health care providers who reported sometimes or never rendering RMC.

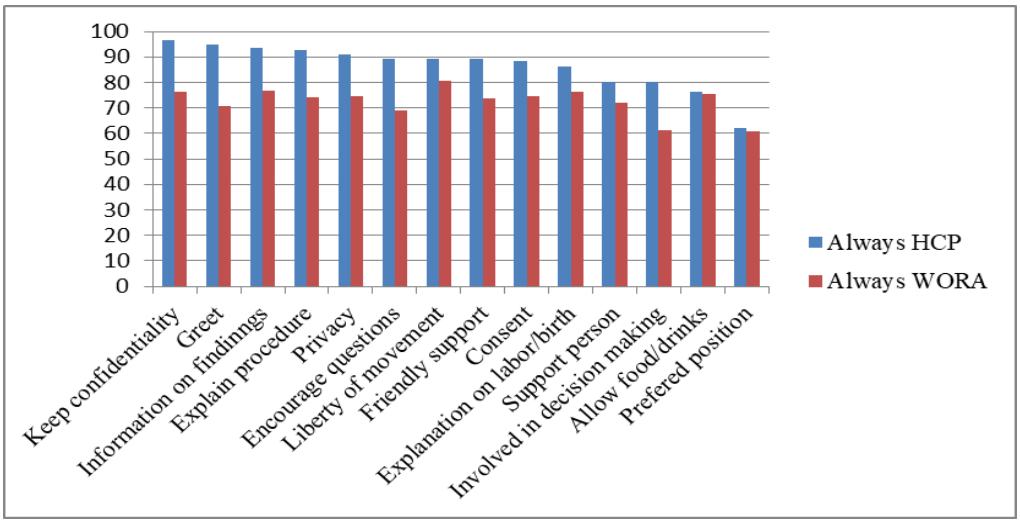

Figure 2. Proportion of Health Care Providers (HCP) who reported always practicing RMC compared to proportion of Women of Reproductive Age (WORA) who reported always receiving RMC

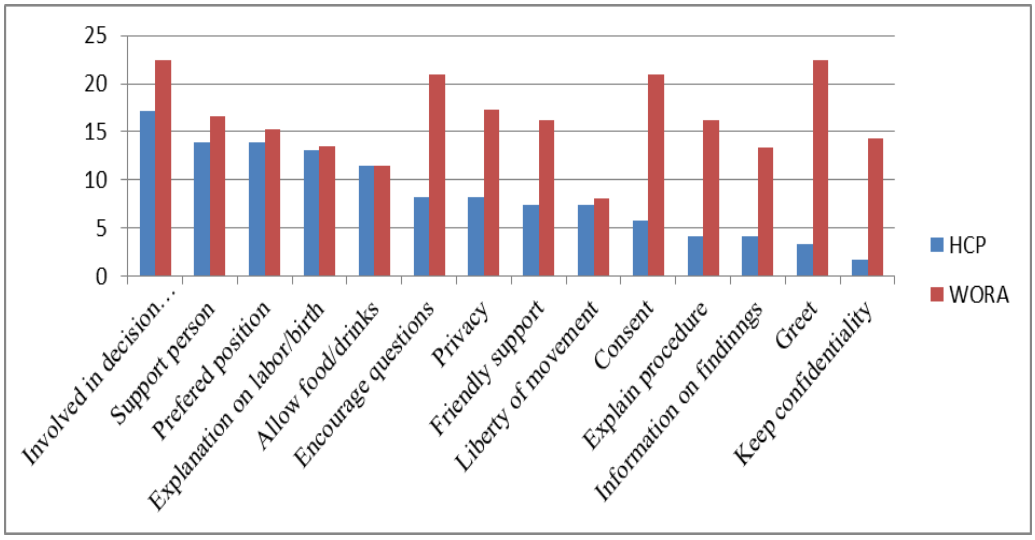

Figure 3. Proportion of Health Care Providers (HCP) who reported sometimes practicing RMC compared to proportion of Women of Reproductive Age (WORA) who reported sometimes receiving RMC

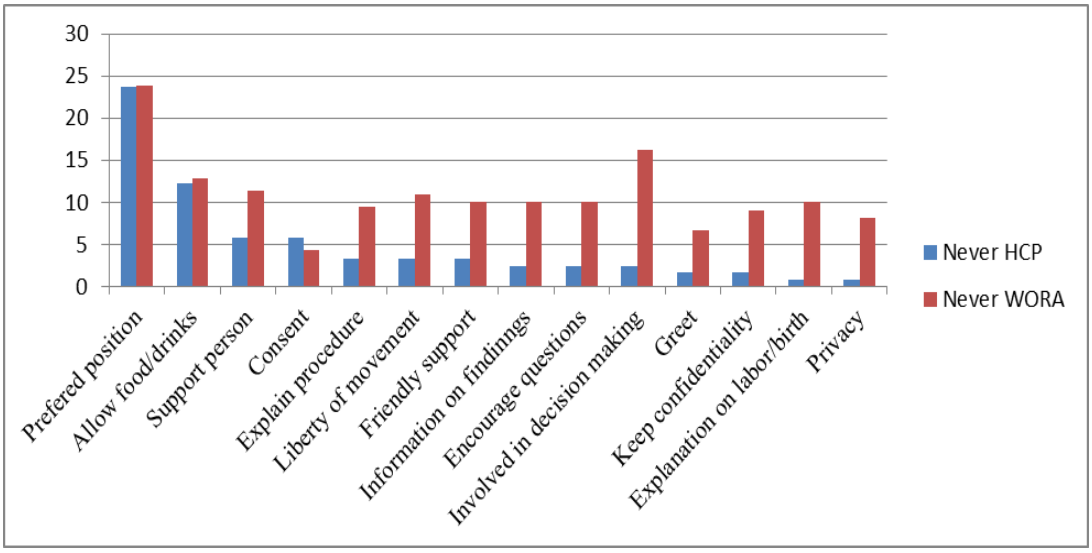

Figure 4. Proportion of Health Care Providers (HCP) who reported never practicing RMC compared to proportion of Women of Reproductive Age (WORA) who reported never receiving RMC

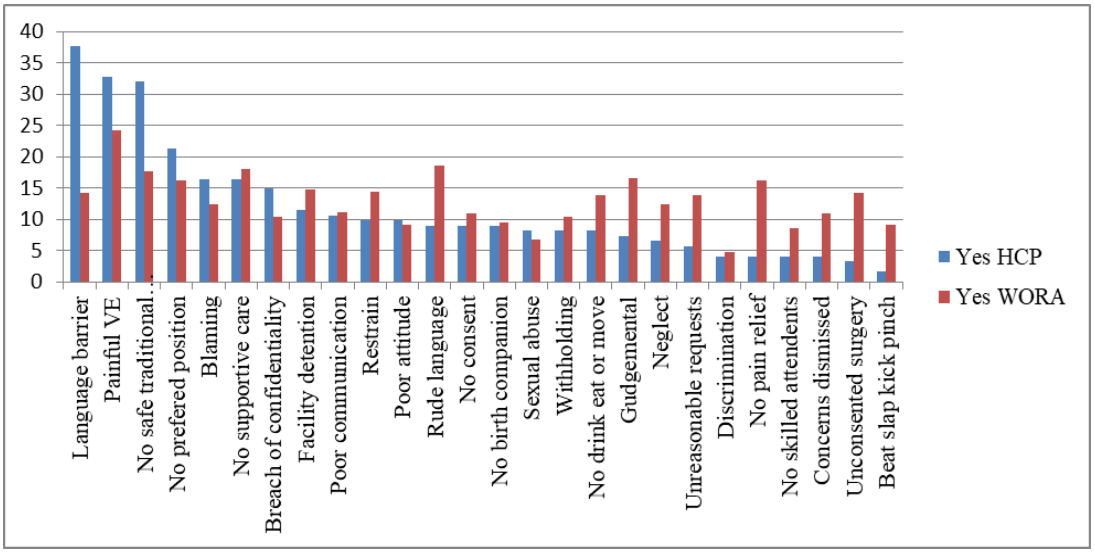

Figure 5. Proportion of Health Care Providers (HCP) compared to proportion of Women of Reproductive Age (WORA) who reported incidents of mistreatment (non-RMC)

In regard to the mistreatment of women during labor and/or childbirth, the most common practice reported by health care providers was navigating language and interpretation issues while the least common was beating, slapping, kicking, or pinching. For women of reproductive age, the most common form of mistreatment was painful vaginal examinations while the least common was discrimination. In general, as presented in Figure 5, more women of reproductive age reported incidents of mistreatment than did the health care providers.

Health care providers were asked about personal or professional challenges that prevent them from rendering RMC. Respondents cited heavy workloads, low salaries and delayed payment, poor motivation, limited knowledge on RMC, language barriers, as well as shortages of medical supplies and equipment as challenges. The following extracts reflect these issues:

Heavy duty due to few staff compared to number of mothers

Not enough midwives and heavy workload

Shortage of staffing with high workload

Heavy workload, low salaries and delayed payment

Poor motivation and low salary

There is little knowledge on RMC, lack of supplies

Lack of training is making me not to render RMC

I have limited knowledge on RMC, heavy work load, poor motivation

Language barriers, lack of training on RMC

Sometimes there is communication barrier

Lack of equipment and material, long hours work, insufficient staff

When asked about opportunities that have enabled them to render RMC services, some health care providers stated that they had not been presented with any such opportunities. Those who perceived themselves to have opportunities to practice RMC mentioned the importance of knowledge and skills, feedback from colleagues and clients, a supporting enabling environment, refresher courses, as well as intrinsic personal motivation. This is reflected in the following extracts:

…personal knowledge and skills,
…knowledge on RMC
Encouragement from colleagues
Appreciation by the community and clients
Favorable hospital policy
Cooperation from staff and patients
There are translators in case of language barrier
Organized facility system
Frequent trainings
Training on RMC, communication skills
Mentorship from senior staff
My passion to work
My passion to care for the community
Self-motivation

4. Discussion

This study's first objective was to 'assess the level of understanding of RMC and related clinical practices among health care providers, as well as gaps in knowledge and skills for the uptake of RMC at targeted health facilities in the project regions ("What midwives want")'. The findings of this study indicate a limited understanding of RMC among health care providers. This was evidenced by the fact that while most health care providers in this study have heard about RMC either occasionally or often (with only 8% having never heard about RMC), when asked about what RMC meant to them, less than half of health care providers demonstrated a correct understanding of what RMC consists of by giving an answer that aligned with one or more of the 12 domains of RMC. Some domains of RMC (such as provision of efficient care and the importance of communicating effectively with patients) were not cited at all, while others were cited by just a few health care providers. Furthermore, the findings of this study point to a limited understanding of SRHR among health care providers, as only 40% were able to provide an answer that was specific to SRHR and only 2 domains of SRHR (fertility control and equitable services) were frequently cited.

With respect to RMC clinical practice, there appears to be a discrepancy between the perceived ability to render RMC services and the experience of the women who receive the services. For example, the majority of health care providers, including those who did not succeed in citing any domain of RMC, indicated that they were very confident or confident in providing RMC. In addition, the proportion of women of reproductive age who reported always receiving RMC was lower than the proportion of health care providers who reported always rendering RMC, while the proportion of women of reproductive age who reported sometimes or never receiving RMC was generally higher than the proportion of health care providers who reported sometimes or never rendering RMC. Both health care providers and women of reproductive age reported incidents of mistreatment. The discrepancy in perceived ability and lived experiences could be due to a lack of understanding on what constitutes RMC among health care providers, or other factors influencing negatively on the experience of women that go beyond the care received from individual providers (for instance, infrastructural constraints). This discrepancy could also be due to health care providers knowing and therefore selecting the answers that are generally more acceptable, a phenomenon referred to as social desirability bias [12].

Findings of this study indicate that there are gaps in knowledge and skills among health care providers. Respondents cited that staff were too old and had poor and outdated knowledge, highlighting the need for trained health workers to provide quality services. Limited knowledge of RMC was cited as one of the challenges that prevented health care providers from rendering RMC. Other challenges were also cited, including the limited number of staff, poor motivation among the few available staff, as well as shortages of supplies and equipment. Due to insufficient staffing at health facilities, it may be more difficult to allocate time for continuous professional development as one must choose between attending to clients and attending a training, if any is offered. This could lead to limited knowledge, which, when coupled with a general shortage of supplies and equipment as well as other de-motivators, may result in lack of job satisfaction. Poorly motivated staff members may then opt to absent themselves from work, in turn aggravating the shortage of experienced staff in health facilities. These linkages are schematically depicted in Figure 6.

With regards to the needs of health care providers, the findings of this study indicate the need for both general and RMC-focused capacity building, increased salaries and other forms of motivation, and ensuring supplies and equipment are made readily available. Other identified needs include establishing a conducive working physical environment, increasing the number of health care providers, and availing guidelines on RMC.

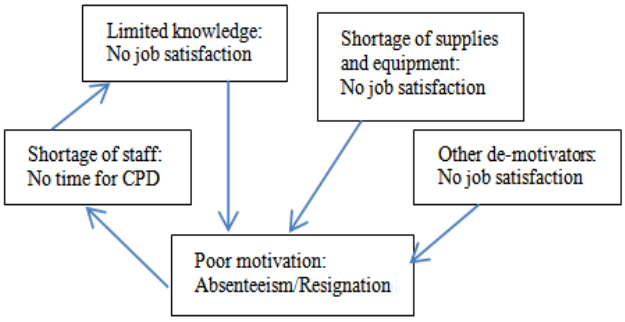

Figure 6. Schematic presentation of factors likely to influence limited knowledge and skills among Health Care Providers

This study's second objective was to assess 'the level of understanding of RMC and SRHR among women of reproductive age (including adolescent girls and women with disabilities), as well as women's current experiences of care, unmet needs, and preferences at targeted health facilities in the project regions ("What women want")'.

Regarding the level of understanding of RMC and SRHR, close to half of the women of reproductive age interviewed had never heard about RMC, and only 31% gave an answer that aligned with one or more of the 12 domains of RMC when asked about what RMC meant to them. Furthermore, half of the women of reproductive age in this study were not able to provide any example of SRHR. Key elements of SRHR, including access to contraception and prevention of GBV, were not cited by any women of reproductive age, pointing to a gap in awareness of their own sexual and reproductive health rights. These findings

emphasize the need for RMC and SRHR sensitization activities that target the service consumers.

Regarding women's current experience of care, unmet needs, and preferences, findings in this study indicate that some women of reproductive age are mistreated during labor and/or childbirth. This suggests the need for RMC and SRHR awareness activities that target service providers in order to prevent these forms of mistreatment. Women of reproductive age in this study indicated that some health facilities had few staff members, rooms and surroundings were not clean, and rooms lacked privacy. These findings are likely to negatively affect how women feel about the care received from such health facilities. The results of this study further indicate that the presence of staff who provide services in a respectful way is highly valued by women of reproductive age. However, based on women's inputs, this must be combined with improvements to the physical environment and resource availability in order to truly transform the experience of care.

This study's third objective was to assess 'the level of understanding of RMC and SRHR among key stakeholders (health facility administrators, men, youth representatives) as well as their views and perceptions of women's SRHR in targeted communities within the project regions. Findings of this study indicate that there is a limited understanding of RMC and SRHR among key stakeholders. This is evidenced by the fact that less than half of key stakeholders could give an answer that aligned with one or more of the 12 domains of RMC, although 70% of key stakeholders had indicated that RMC was a commonly used terminology. Furthermore, 72% of key stakeholders could not cite any domain of SRHR, while 34% did not provide an example of SRHR, indicating an incomplete understanding of women's SRHR. These findings highlight the need for RMC and SRHR awareness activities that target stakeholders in the communities, who can act as key enablers or inhibitors to the provision of RMC.

Nevertheless, key stakeholders indicated that there was a need for health care providers to preserve women's dignity and maintain privacy and confidentiality. Stakeholders also reported incidents of women being mistreated during labor and/or childbirth. As such, these findings reinforce the importance of RMC and SRHR awareness and/or training activities targeting health care providers themselves.

Key stakeholders further mentioned some challenges in the provision of RMC, including the limited number of staff available to render maternity services, low or no motivation among the few available staff members, shortage of equipment and supplies, and non-conducive physical working environments. Health care providers also expressed similar challenges. These inputs point to broader systematic and infrastructural constraints which fall outside the purview of knowledge and awareness-generating activities, but are equally important to address in order to ensure that RMC learnings can be translated into practice.

5. Conclusion

Despite a noticeable decrease over the past ten years, South Sudan still ranks among the countries with the highest maternal and neonatal mortality ratio in the world. The provision of a care that is more client-centered and culturally sensitive, such as Respectful Maternity Care in a Sexual and Reproductive Health and Rights enabling environment, is key to reducing maternal and neonatal mortality. The results of this study reveal a set of challenges that should be addressed by the Ministry of Health and implementing partners in order to support the provision and scale up of Respectful Maternity Care in South Sudan.

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Conflict of Interest Statement

The authors have no competing interests.

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