SOCIAL NORMS AND REPRODUCTIVE HEALTH AMONGST THE FERTIT PEOPLE OF WESTERN BAHR EL GHAZAL, SOUTH SUDAN

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SOCIAL NORMS AND REPRODUCTIVE HEALTH AMONGST THE FERTIT PEOPLE OF WESTERN BAHR EL GHAZAL, SOUTH SUDAN

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ACCOUNT

Chapters 4 to 8 are based on co-authored articles that have been published or are under review for publication in peer-reviewed journals. In these co-authored articles, the we form is used to acknowledge and reflect the contributions of all co-authors.

Chapter 4

Chapter 5

Chapter 6
Kane S, Miedema E, Dieleman M, Broerse JEW. “You have a child who will call you 'mama’” – understanding adolescent pregnancy in South Sudan. Under Review.

Chapter 7

Chapter 8
INTRODUCTION
While great progress has been made towards improving population health across the world, many low-income countries continue to struggle; these struggles are most marked in the realm of sexual and reproductive health (Starrs et al 2018). Sexual and reproductive ill health continues to account for more than 30% of the global burden of disease among women of reproductive age, including adolescents (Singh et al 2014). This translates into almost 20% of the global burden of disease among the population overall (Singh et al 2014). The recent Guttmacher–Lancet Commission on sexual and reproductive health and rights, highlights and reiterates the centrality of improving sexual and reproductive health (SRH) services to improving global population health (Starrs et al 2018). They argue that efforts and investments need to be made to improve the availability, accessibility and quality of sexual and reproductive health services, for adults and adolescents alike – particularly for women. They add that, 

Countries must also take actions beyond the health sector to change social norms, laws, and policies to uphold human rights. The most crucial reforms are those that promote gender equality and give women greater control over their bodies and lives (Starrs et al 2018 p 7).

It is also widely recognised that to be effective, SRH services need to not only be evidence based, but also tailored to local contexts (De Francisco et al 2007). The Global Reproductive Health Strategy adopted by the World Health Assembly in 2004, emphasizes that SRH services can only be accessible and responsive to local needs if they explicitly consider the local social norms, beliefs, and values on matters of reproduction and fertility. Ferguson & Desai (2018), writing about the approaches to translating the Guttmacher-Lancet Commission's global report to local action, reiterate these principles – arguing that to improve acceptability and ultimately use of SRH services, the expectations, concerns, worries and preferences of the local population, including the adolescents, have to be thoroughly understood and accounted for.

While to some extent, many low-income countries have had remarkable successes in overcoming constraints related to availability of health services, issues around accessibility and quality of services remain (Black et al 2016, Starr et al 2018). The latter has meant that in many contexts, people often do not use the available services. This holds particularly true for contexts that are post conflict, and/or are experiencing ongoing conflict or insecurity (Starr et al 2018) – South Sudan is one such country. Of all the low-income countries in the world, South Sudan has one of the poorest population health situations (MOH 2013). The burden of sexual and reproductive ill health amongst women and adolescent girls is very high (MOH 2013). For instance, it is estimated that almost 90% of women still deliver at home, and 23% of all women experience complications during pregnancy and delivery. Similarly, it is estimated that maternal mortality is between 789 and 2056 per 100,000 live births (MOH 2013, 2015). The national reproductive health policy of 2013 (MOH 2013) estimates that: the national fertility rate is at 7.1 children being born per woman; about 33% of all girls marry before the age of 19; and 33% of females had had a child before the age of 18. While reliable data about the reproductive health
burden, including the burden of maternal mortality and morbidity, disaggregated by age are not available, it is reasonable to expect that adolescent girls bear a large proportion of the burden of reproductive ill health. Further, while in large parts of South Sudan, availability of SRH services remains a problem, in some parts where SRH services are available, people still do not use these services. At many levels this whole situation is the result of decades of war before independence in 2011, and the ongoing civil conflict since then. The lack of governance and political stability have meant that health facilities have been destroyed and services have been disrupted (MOH 2015).

Evidence shows that chronic insecurity and instability not only affect health through breakdown of services, they also influence how people make decisions about their lives, including about their health and reproductive health; it also shapes the social structures, social relations, including the social norms, beliefs, and values on matters of reproduction and fertility (Ityavyar & Ogba 1989, Jansen 2006, Mc Ginn et al 2014, Urdal & Che 2013). The Guttmacher–Lancet Commission on sexual and reproductive health and rights, emphasizes the importance of addressing SRH in conflict, post-conflict and fragile settings – it argues that the greatest vulnerabilities are in these contexts, and makes a strong case for directing global health efforts to such contexts (Starrs et al 2018). Haar & Rubenstein (2012) in their comprehensive review of health and conflict propose an agenda for research – among other topics, they call for inquiries which critically examine how conflict, related contextual factors, culture, and other societal characteristics influence health. They argue that such insights are essential for informing the processes of health system reconstruction. In the same vein, Tanyang (2018) in writing about the political economy of sexual and reproductive health in crisis situations, makes a case for inquiries which explicitly engage with women’s concerns in crisis situations for they are most vulnerable in such circumstances. She argues for inquiries to examine how gender relations shaped at the intersection of political, economic, and sociocultural processes, influence sexual and reproductive health, particularly women and adolescent girls. The research presented in this thesis responds to the concerns raised by the Guttmacher–Lancet Commission; it does so by engaging with the research priorities identified by Haar & Rubenstein (2012) and by Tanyag (2018), in the context of South Sudan. In doing, it addresses a gap in the knowledge on local social norms, beliefs, and values on matters of reproduction and fertility in the study area.

The research presented in this thesis took place within the broader framework of the South Sudan Health Action Research Project (SHARP), which was implemented between 2012 and 2016, with the aim of contributing to improving reproductive health outcomes in four states of South Sudan. The SHARP project was designed to support the implementation of the National Sexual & Reproductive Health Strategic Plan (2013-2016 plan). SHARP sought to contribute to achieving four outcomes: 1. To improve availability, accessibility and quality of sexual and reproductive health (SRH) services; 2. To enhance capacities at all levels of the public services to deliver quality comprehensive SRH services; 3. To empower women, families and communities to exercise their right to access good quality SRH services; 4. To generate knowledge to help make SRH services context appropriate and responsive to local needs. In the next chapter,
the burden of reproductive ill health in, and health services context of, the SHARP project area is elaborated further.

The research presented in this thesis was conducted as part of the 4th objective of the SHARP project. With a view to identify research questions and research priorities for the 4th objective, intensive consultations were held with stakeholders and local actors. During these consultations it emerged that there were many gaps in relation to SRH related knowledge in the projects' intervention areas. It was widely recognised that to make SRH services accessible and responsive to local needs, one needed to have good insight into the social norms, beliefs, and values on matters of reproduction and fertility. People in the study area confirmed that deep insight was needed on how social norms and gender relations in the local society shaped preferences and actions of men and women on matters related to reproduction, fertility and use of SRH services. An example that came up often in these discussions related to the need to understand the reasons behind the increase in the number of adolescent pregnancies in the study area. During the consultations it was emphasized that the expectations, concerns, worries and preferences of the local population, including the adolescents, were not known, and needed to be thoroughly understood. Consultations further stressed the great diversity of cultural contexts within South Sudan and highlighted the need for gaining these insights across the diverse contexts. To specify, it was pointed out that South Sudan was home to at least 50 different groups – with a wide variety of cultures, and related social norms, beliefs, and values on matters of reproduction and fertility. Stakeholders emphasized the fact that one of the proposed intervention areas of the SHARP Project, the Western Bahr el Ghazal (WBeG) State, was predominantly populated by one particular group of people (the Fertit) about whom, little had been studied and written; they argued for the need for research to learn more about the social norms and social relations amongst the Fertit, and how these shaped actions in the reproductive realm. While there was substantial work about the lives and society of the dominant pastoralist people of South Sudan (the Dinkas, and the Nuer), little was written about other people. A literature review conducted during the first phase of SHARP, confirmed the knowledge gaps identified in the consultations. The need for this research was confirmed by the local stakeholders in South Sudan as of crucial importance – there was broad support for the inquiry.

These observations from the stakeholder consultation process echoed what social policy researchers have long recognised - the influence of social norms, the informal rules of behaviour that dictate what is acceptable within a given social context, on human behaviour. These observations were also consistent with the extant health literature which places a deep understanding of local social norms at the core of effective health promotion and behaviour change interventions (Mollen et al 2010). Such interventions draw on insights about social norms to trigger positive norm change through influencing a mix of peer processes, key social relational arrangements, and broader societal structures. In the last two decades, empirical research in various health domains has firmly established the importance of having a sound understanding of social norms, both as a way to explain why people behave the way they do, and also as the basis to inform interventions to positively influence people's health-related choices (Borsari & Carey 2003, Eisenberg et al 2005, Rimal & Real 2005, Mc Alaney & Jenkins
There is a growing body of empirical work which demonstrates the effectiveness of social norms-based interventions for improving reproductive health. For instance, Haylock et al (2016) present a compelling case of how insights about social and gender norms can help the development of effective interventions for shifting negative social norms and unequal gender and power relationships to prevent violence against women and girls. Similarly, Read-Hamilton and Marsh's (2016) work on changing social norms to end violence against women and girls in conflict-affected communities implemented in Somalia and South Sudan, provides a compelling example of how deep insight into social and gender norms can help inform culturally appropriate and effective public health policies and programs. Also, in the reproductive health realm, social norms theory has been used to gain nuanced understanding of persistence of female genital cutting in certain communities. Insights thus gained have been used to design interventions to effectively target social norms around female genital cutting; the success of these interventions affirms the importance and relevance of such social norm informed approaches (Diop et al 2008, Miller and Prentice 2016, Tankard and Paluck, 2016, Cislaghi 2018).

Much of this work on the importance of social norms in health-related behaviours and actions of people draws on Cialdini et al's (1990, 1991), and Cialdini & Trost's (1998) conceptualisation of social norms. They distinguish between two distinct types of social norms: (i) beliefs about what others do (descriptive norms) and (ii) beliefs about what others approve and disapprove (injunctive norms). People tend to comply with descriptive and injunctive norms for a variety of reasons, primarily the anticipation of social approval or of sanctions for compliance and noncompliance, respectively (Bicchieri 2006, Elster 1989, Elster 2007). The enforcement and maintenance of these informal rules of behaviour occurs through a combination of peer/group processes and broader social influences; the latter can act independently or be mediated through group processes (Cialdini et al 1990, 1991). In this study Cialdini et al's conceptualisation of social norms is used.

**AIM OF THE STUDY**

Given the above, the aim of this study was to gain insight into the ways in which social norms and social relations in the Fertit society shaped the sexual, reproductive, and reproductive health related decisions and actions of the Fertit people. The study specifically sought to gain insight into women's and adolescent girls', reproductive choices and actions by examining them in the context of social and gender identities and relations in Fertit society and by interrogating these social relations in light of the broader social, cultural, political and economic environment. The focus throughout was on understanding why things were the way they were, and why people, particularly women and adolescent girls, did what they did. The purpose was to use this insight to inform improvements in the reproductive health practices, programs, and policies, to make them more responsive to the needs of the local population. At another level the agenda was to demonstrate the value of such contextualized insight, and to in the process, encourage similar research amongst other communities of South Sudan.
The Overarching Research Question of the study was,

How do social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit people?

OUTLINE OF THE THESIS

This thesis is structured as follows. The next chapter (Chapter 2) locates the research within the current and historical context of the study area (South Sudan generally, and Western Bahr el Ghazal State, specifically). It also presents an overview of the theoretical and conceptual considerations entailed in answering the research questions. The conceptual framework guiding the research is presented – its rationale and appropriateness are examined, the constraints and steps taken to overcome these constraints are discussed. Further, a detailed mapping of the concept of social norms is presented with a view to locate the research within the existing theoretical knowledge on the subject.

Chapter 3 details the research design. It begins with a specification of the overall research questions into five specific research questions. This is followed by an articulation of the research approach chosen. A brief sketch of the historical evolution of and the disciplinary approaches to studying reproductive behaviours and actions, helps place the chosen interdisciplinary research approach, in perspective. This chapter also details the methodology, the methods, study processes, and analytical steps taken. A reflection of the ethical considerations, the steps taken to address these, and on the steps taken to ensure research quality and rigor, is presented.

Chapters 4-8 present the findings – these relate to the five specific research questions. Each of these chapters is by itself a complete piece of academic output, published as a paper in an international peer-reviewed journal. Therefore, these papers have some duplications, particularly in the introduction/background/context and methods sections; this is so because the papers draw upon the same dataset. However, for the purpose of this thesis, the linkages are more pertinent. Each paper actively engages with and addresses the overarching research question on how social norms shape behaviour and actions in the reproductive realm. Each paper sheds light on a unique aspect of the overall research question – this is articulated in the specific research questions outlined in Chapter 3. To do so, each chapter/paper links to and draws upon one or more theoretical considerations outlined in Chapter 2; this allows one to provide a multifaceted and rich explanatory account of the phenomenon under study. In each of Chapters 4-8, for the unique aspect of the reproductive realm being addressed, implications of the findings for action on policy and practice are also presented. These reiterated and extended in Chapter 9.

In Chapter 4, in examining the family planning decisions and actions amongst the Fertit, to explain how social norms shape these actions, insights are drawn from theories of normative social behaviour (Cialidini et al 1990; Kallgren et al 2000), theories of fertility and demographic change (Caldwell 1976, Caldwell & Caldwell 1987), and from theories of masculinity (Connell
1995). Drawing upon these middle range social theories, an attempt is made to proffer alternative explanations about why men and women make the decisions they make regarding fertility, spacing, and family size.

In Chapter 5, in examining how gender relations shape women's reproductive health, insights are drawn from gender theories (Connell 2009), and from the theoretical interface of postcolonial studies and gender studies (Sudarkasa 1996; Oyewumi 1998, 2002, 2011; Morrel 2016). Drawing upon these feminist epistemologies and middle range social theories, an attempt is made to proffer alternative explanations about how gendered social relations shape decisions and actions regarding fertility, spacing, and family size. In proffering these explanations, the analysis builds upon and links to the theories of fertility and demographic change (Caldwell 1986, Caldwell & Caldwell 1987), and theories of masculinity (Connell 1995), that were invoked in Chapter 4.

In Chapter 6, in trying to make sense of and explain the high prevalence of pregnancy amongst adolescent girls, insights are drawn from middle range theories of life course and social roles (Hagan & Wheaton 1994). These insights help to unpack and reveal the symbolic importance of motherhood as a state of being and its potential to catalyse social mobility, specifically, the exit from the world of minors into the world of adults. Throughout the analysis, appropriate links are made to the theories of fertility and demographic change (Caldwell 1976, Caldwell & Caldwell 1987), and the relational theory of gender (Connell 2009). Explanations are proffered by locating adolescent girls' actions within the broader context of conflict and insecurity.

Chapter 7 draws upon the middle range theory of 'responsibility assignments and practices' (Walker 2007; Watson 1996) in society, and on the theories of masculinity (Connell 1995), to unpack the narrative of male reproductive responsibility – a major and recurring narrative in the data. Drawing on these theoretical insights, an attempt is made to provide an explanatory account of what these responsibility assignments in the reproductive realm might connote. Invoking the theoretical understanding it is argued that these responsibility assignments and practices constitute and represent the social structure itself, and that they serve to reinforce and reproduce the gendered social inequalities in the reproductive realm.

In Chapter 8, the explanations for some women's non-use of maternal health services are revealed at the intersection of theoretical understandings on local social norms, gender relations, and responsibility assignments on one hand, and the theories on social fears (Tudor 2003) and social dignity (Jacobson 2007, 2009) on the other hand. The chapter highlights that the act of seeking care is a social act which entails many social interactions, in a variety of social spaces. In doing so, the chapter extends our conceptual understanding of what accessibility of health services should include. It makes the case for the inclusion of and explicit attention to, social accessibility as a dimension of accessibility of health services. It also argues that dignified and responsive services should not be narrowly interpreted as the mere upholding of patient's/ people's dignity during the care encounter alone, but instead that truly responsive services should work towards upholding people's dignity in all the spaces they traverse and occupy in the process of seeking health care.
In Chapter 9, research findings are discussed in view of the extant theoretical literature and empirical work on the subject, with a focus on social norms in the reproductive realm. The chapter examines key themes within and across each of the 5 findings chapters, and in doing so, the consistencies, differences and contradictions between the extant literature and the study findings, are discussed. Throughout the discussion, implications are drawn for action on reproductive health policy and practice in South Sudan. In Chapter 9, I also share my reflections on my experience in conducting this research, and on the research process. The chapter ends with an articulation of a brief agenda for future research.


Haar, RJ., Rubenstein, LS. (2012) Health in fragile and post-conflict states: a review of current understanding and challenges ahead, Medicine, Conflict and Survival. 28:4, 289-316


Walker, MU. (2007). Charting responsibilities: From established coordinates to terra incognita. In:

CONTEXTUAL AND THEORETICAL BACKGROUND
The first part of this chapter outlines the broader context of South Sudan with a view to locate the research within a relevant current and historical context. A brief account of the diverse people and their cultural context is provided. The recent history, emergence of this new nation, and the current geopolitics are briefly presented. The population health and the state of the health system are presented in some detail. Where data/literature are available, the situation in Western Bahr el Ghazal state, and/or Wau (the study area), is highlighted. The second part of the chapter presents an overview of the key concepts and theoretical considerations as they relate to and are applied in the study.

THE CONTEXT OF SOUTH SUDAN

South Sudan is a large, multi-ethnic, multi-religious, multi-cultural nation with an estimated population of 12.32 million (NBS 2018). It is home to more than 50 different people; at the national level, the Dinka, the Nuer and the Shilluk people constitute the largest groups. At the national level, while the Dinka and the Nuer people constitute a sizable part of the population in many of the erstwhile 10 states of South Sudan, in some states other ethnic groups tend to predominate. For instance, in the erstwhile Western Bahr el Ghazal State, the Fertit (or Fartit) people form the largest population group. The moniker Fertit is used to refer to a loose conglomeration of more than 23 Non-Dinka, Non-Arab, and Non-Luo people. This cultural diversity has long been a subject of study by sociologists and anthropologists. Charles Seligman, and his student, Evans Pritchard, pioneered the field of social anthropology through their work on the people of Southern Sudan in early 20th century; Seligman through his work on the Shilluk people, and Evans Pritchard through his work on the Azande, Bongo and Nuer people. Scholars have acknowledged the simultaneous diversity and complex overlaps between the identities of the different people of South Sudan, particularly so amongst the smaller Non-Dinka, Non-Nuer people, and specifically the people inhabiting the Bahr-el-Ghazal states. In some ways this complexity is exemplified by the title of an article that Tucker wrote in the 1931 Edition of the Sudan Notes & Reports - the title is ‘The tribal confusion around Wau’ (Tucker 1931). Johnson (2016 p76) in his recent work acknowledges that the situation is not much different in the current times. He adds that as South Sudanese intellectuals seek to replace English terms with indigenous self-names, this confusion is likely to continue, and even be exaggerated (Johnson 2016 p20). In any case, the cultures of different people of South Sudan have evolved and changed substantially under pressures from sociopolitical changes. Historically, this can be attributed to inter-tribal interactions, colonial influences (British and Arab), and Islamic and Christian proselytization influences. In the last few decades, modernization, the long-drawn wars for independence, and civil unrest, have also contributed to this change through uprootment and disruption of communities.

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1 The term ‘people’ is used in line with Ferguson and Whitehead (2000, p15) who argue that tribes are “bounded and/or structured political organisations” and ethnic groups are “a cultural phenomenon with only latent organizational potential”. The term ‘people’ is thus used to allow for a more general articulation.
The Fertit people of Bahr El Ghazal

The Fertit people inhabit the flood plains of the Bahr-el-Ghazal river; they are spread across the two erstwhile states of Northern and Western Bahr el Ghazal, primarily the latter. They are concentrated around Wau town, the second largest town in South Sudan, and towards the town of Rajah, located 300 kilometers towards west (and north west) of Wau. Wau Town (and the Wau County within which it is located), is highlighted (circled) in Figure 2.1 below.

Reliable census data for South Sudan generally, and at state level specifically, are not available. It is estimated that the population of the erstwhile Western Bahr el Ghazal State is approximately 550,000. Table 2.1 presents key demographic features of WBEG state – the table draws on data from the National Bureau of Statistics of South Sudan (NBS 2018). While accounts from the literature vary (both in detail, and in nomenclature), based on discussions with various tribal elders, the major Fertit people living around Wau are the Balanda (Balanda Boor, Balanda Bviri, Balanda Bagari), the Gollo, the Bai, the Ndogo, the Kresh, and the Njolo. Other non-Fertit people also live in and around Wau town - they include the Dinkas, the Jur and the Jur Chol; the latter constitute the major population group in the Jur River county located to the South East of Wau town. According to the tribal elders, the Fertit are different from the Dinkas in that unlike the Dinkas, they are not pastoralists, but rather are subsistence farmers. Unlike

![Image](https://example.com/south-sudan-map.png)

Figure 2.1. Map of South Sudan: Wau county in Western Bahr el Ghazal State is circled (Source: United Nations).
the Dinkas and other pastoralist people of South Sudan (e.g. the Nuer people) who marry using cows as bride price, all the Fertit groups marry through the exchange of agricultural tools (e.g. ‘hoes’) and exchange of money (traditional money and the new paper money).

While each of the abovementioned Fertit group is unique, village elders consistently indicated that that the commonalities in terms of culture and social norms, far outstripped the differences between the groups. One of the key reasons that was cited related to marriage practices; marriages across different Fertit people is common, except that marriage into the mother’s clan/lineage is prohibited. Polygyny is part of the tradition (Seligman 1932 pp 460-494), and many chiefs and important men continue to have multiple wives. All the Fertit people are patrilineal. Traditionally, the payment of the bride price is underpinned by the expectation that the bride will bear children for the man’s family; in some Fertit people, if in due course, the bride does not bear children, her family would have to return part of the bride price to the man’s family (Seligman 1932 p483). Almost all Fertit have adopted Christianity but retain elements of traditional faiths. The relations between the Fertit and the Dinka people have historically been shaped by hostilities centered around access to grazing lands – with disagreements about which lands were whose, and where/when the Dinka could graze their cattle; earliest accounts of the tense relations include those by Santandrea (1933, 1948).

Ongoing conflict

After two long wars (1955-1972, and 1983-2005) for independence from Sudan, the southern part of the erstwhile Sudan, became an independent nation state in 2011 – the new country is called South Sudan. The transition to nationhood has been difficult for South Sudan. Since independence, the country has been in a state of chronic, low-grade conflict. Along its northern borders, it is engaged in a border and territorial dispute with Sudan from which it gained independence; this dispute has meant that South Sudan has lost access to commercially important sea ports which are critical for import of goods, and for export of crude oil (potentially the most important revenue source for South Sudan). In addition, the country is also beset with internal civil-political conflict centered around disagreements between different political groups on matters related to political power sharing. Initially, the internal conflict was

<table>
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<th>Population characteristic</th>
<th>Estimates</th>
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<tr>
<td>Total population</td>
<td>550,000</td>
</tr>
<tr>
<td>Proportion of women in the population</td>
<td>50</td>
</tr>
<tr>
<td>Proportion of population below 18 yrs of age</td>
<td>48</td>
</tr>
<tr>
<td>Proportion of population that is literate</td>
<td>34</td>
</tr>
<tr>
<td>Proportion of women who are literate</td>
<td>39</td>
</tr>
<tr>
<td>Proportion of population below national poverty line</td>
<td>43</td>
</tr>
<tr>
<td>Proportion of households dependent on farming or animal husbandry as their primary source of livelihood</td>
<td>64</td>
</tr>
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limited to small parts of the country; however, the upsurges in 2014 and 2016 saw it spread to large parts of the country, and also become much more violent. The worst hit states have been the erstwhile Upper Nile, Unity, Jonglei and Warrap states; Western Bahr el Ghazal state, the site of this study, has seen comparatively less violence (with 2016 being the exception). Because of the internal civil-political conflict, at the national level, nearly 4 million persons have been displaced. Approximately, 1.9 million are displaced internally, and around 2.1 million have been displaced to neighboring countries, primarily to Uganda, Kenya and Ethiopia. It is estimated that thousands of people have lost their lives in these ongoing conflicts; however, the number of casualties cannot be confirmed (OCHA 2018).

While it is beyond the scope of this work to dwell upon the nature and intricacies of this highly complex internal civil-political conflict, it is worth noting that the conflict is definitely not along simplistic ethnic lines, as is often reported by international media. Douglas H Johnson (2016 p 180), in his recent book ‘South Sudan: a new history for a new nation’ notes that,

Despite the ethnic character of the first few months of the war, the South Sudanese as a whole did not respond to attempts at ethnic mobilization (...) there are signs of hope in the failure of ethnic mobilization.

That said, the ongoing insecurity and instability has upended the many development gains that were made in the periods before and immediately after independence, including but not limited to, in health development.

**Health Services**

Much of the public health infrastructure has been destroyed in the decades of war before independence, and in the ongoing civil conflict since independence. While reliable data on the number of health facilities, number of functioning health facilities, and human resources for health, are not available – according to current estimates, there are 2115 active health facilities in the country. Table 2.2 gives the distribution of facilities by type (HRIS 2018). In terms of health infrastructure, there are large differences across the country, with some states faring better than others, and urban areas faring better than the rural and remote parts. It is estimated that in South Sudan: 28.6% of the population live within a five-kilometer radius of a functional health facility (Macharia 2016); there are approximately 7419 active health staff in the country (HRIS 2018); and the per capita outpatient services utilization rate is approximately 0.2 visits per annum.

Health infrastructure related differences notwithstanding, the staffing situation and the quality of services at existing facilities, is poor across the country. The national reproductive health policy of 2013 estimated that while about 45% of all pregnant women had at least one visit with a ‘skilled’ provider, only 9.3% of pregnant women would complete the fully recommended protocol of four or more antenatal care visits, and a vast majority delivered at home (86.9%), often without any trained person to assist. About 23% of women experienced complications
CONTEXTUAL AND THEORETICAL BACKGROUND

during pregnancy and delivery; data disaggregated for adolescent girls and adult women are not available. Only few state hospitals could perform emergency surgical procedures such as caesarean sections. Use of modern contraceptives was very low, with only 6.5% of women reporting use of any modern method. Unmet need for family planning was reported by 24% of women, across geographic, wealth and ethnic groups. There were hardly any services geared towards adolescent sexual and reproductive health.

This data was based on the 2010 national household survey conducted in 2010 (MOH 2013). An LQAS (lot quality assurance sampling) based survey of the health system was conducted by the national Ministry of Health in 2014. According to this survey, at the national level, the antenatal coverage stood at 20%, post-natal coverage was at 21%, and only 17% of deliveries were institution based. Health facility and service coverage data at state and county level are not available and are also not reliable. Given the heightened instability since 2016, it is reasonable to say that the situation today is much worse than it was during the study period.

South Sudan is dependent on international donors for much of emergency, social and health services; donors finance and support the delivery of public health care through support instruments coordinated at national and state levels. The health sector support to the country is organised within the ambit of the Health Pooled Fund (HPF), a joint aid mechanism funded by Sweden, United Kingdom, Canada, European Union, Australia, and United States. Between 2012 and 2016, HPF was the key health financing modality in six of the 10 former states (Eastern Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Unity and Lakes); the remaining four states were supported through a financing mechanism led by the World Bank. Since 2016 (till 2018), the United States Agency for International Development (USAID) has joined the pool of donors (replacing Australia); the HPF (now called HPF2) currently (as of early 2018) supports eight of the 10 former states. It operates through 21 implementing partners which work with and support the national, state and county level governments to provide primary health care services in 1,063 health facilities, including 14 hospitals, across 55 of the 86 erstwhile counties. Almost all these implementing partners are international non-government organisations. In addition, national and international non-government organisations provide health services independent of the HPF resources and with varying degrees of coordination.

Table 2.2. Health facilities by type (HRIS 2018)

<table>
<thead>
<tr>
<th>Health Facility Type</th>
<th>##</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care Unit</td>
<td>1468</td>
</tr>
<tr>
<td>Primary Health Care Centre</td>
<td>452</td>
</tr>
<tr>
<td>County Hospital</td>
<td>74</td>
</tr>
<tr>
<td>County Health Department</td>
<td>42</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
</tr>
<tr>
<td>Specialized Hospital / Clinic</td>
<td>28</td>
</tr>
<tr>
<td>State Hospital</td>
<td>10</td>
</tr>
<tr>
<td>Teaching Hospital</td>
<td>4</td>
</tr>
</tbody>
</table>
with the county, state, and national governments. For example, in Wau County three non-government organisations were involved in providing SRH services; of these, one was the HPF implementing partner.

In the health sector, an important aspect of international support also relates to human resources for health. Generally, South Sudan is heavily reliant on foreign health workers for delivering health services; most foreign health workers hail from neighboring Kenya, Uganda and Ethiopia. This dependence is the most severe in the case of higher educated and high skilled cadres like doctors, specialist nurses, and health services managers. While reliable and accurate data disaggregated by location and cadre are not available, the country has a serious shortage of all health cadres, with the situation in some places being better than others, and the situation in areas around the national capital and some places like Wau, being better than other places. For example, in the study area there was one SRH program officer position allocated at county and state health department level - unlike in many parts of South Sudan, both these positions were filled. Similarly, again, while reliable data was not available, in Wau county, at most primary care facilities, all the allocated health worker positions (except doctors) were filled. Wau town also has two hospitals – one public hospital and one faith-based, non-profit hospital. Both have the infrastructure and the personnel to conduct some surgeries, including Caesarean sections. These hospitals serve as the referral hospitals for Wau county and other neighboring counties.

CONCEPTUAL AND THEORETICAL CONSIDERATIONS

To study the social and cultural origins of reproductive behavior, health, and related decision making and care seeking behavior, and to examine how social norms, beliefs, values, expectations and preferences (of citizens, and of service providers) shape these, the Framework of ‘Circles of Influence Affecting Sexual and Reproductive Decisions’ developed by WHO and the Global Forum for Health Research (de Francisco et al, 2007), is used. The framework purports that SRH decisions and their consequences experienced by individuals are shaped by a range of interlinked factors within the household, community, larger society, and the political environment (Figure 2.2). The decision settings are constructed of three layers of contextual factors which interact to influence the sexual and reproductive health of individuals at the centre: the immediate outer layer is of the family in which the individual is located; the layer outside this layer is the community and kinship relations and structures within which the family is situated; the outermost layer of influence includes national political institutions, power structures, and ideologies within which communities are nested.

The framework specifies that,

Within these overlapping spheres of influence, individuals and social groups occupy positions of relative advantage or disadvantage with respect to their access to information and other resources—including their capacity to make decisions—that change over the life course and have important implications for their own and others’ sexual and reproductive health and rights (p 18).
More generally, the framework is rooted in Bronfenbrenner’s ecological framework for human development (1977, 2006), which has been adopted to study human behaviour and action in many social realms. The central tenet of Bronfenbrenner’s ecological framework is the interrelatedness of persons and their context – de Francisco et al have translated Bronfenbrenner’s framework to apply it to the sexual and reproductive health realm. De Francisco et al (2007) draw upon Sen (1990), Khan (1999), Jejeebhoy (2000), and Cottingham & Myntti (2002), to unpack each of the three concentric circles of influence.

According to the framework, the individual at the core is unique; and these unique characteristics, advantages and vulnerabilities, by virtue of age, sex, education, marital status, race, religion, (dis)ability, and location of residence, shape the individual’s reproductive decisions and actions. The immediate outer layer nests the individual within intimate and family relationships; it is in the context of these relationships that one is socialized to form one’s identity, to develop one’s sense of self-worth, to identify with, imbibe and claim entitlements, to recognize one’s responsibilities, to appreciate expectations from oneself. It is also in the context of these relationships that one finds and identifies one’s role models, and gains access to social and economic networks. These relationships and the socialization within them, ultimately thus shape one’s sense of autonomy and control over one’s life, including in the sexual and reproductive realm. These relationships are the source of the material and social resources which mediate one’s ability to exercise this autonomy.

The next outer layer of the framework refers to kinship relations and community institutions like schools, religious institutions, media, and the market. A wide variety of social norms shape both behaviour and opportunities with consequences for SRH related behaviors (decisions, choices and actions); these norms are transmitted, maintained and reproduced through kinship relations and community institutions. The meaning and value given to what constitutes sexual health, reproductive health, satisfaction, distress, motherhood and fatherhood, is also strongly influenced by dominant social norms. Social norms also create powerful ideals of manhood,
womanhood, masculinity and femininity and they define what sexual and reproductive behaviour is appropriate for men and for women, at different stages of life. They condemn or condone certain sexual and reproductive behaviours, expectations, choices and decision-making processes; they may define certain actions and practices as taboo or desirable. Social norms and values have influence on access to resources, both material and social, and also information, which together are necessary for one to fully exercise agency in the reproductive realm. Community institutions further include health and social services – they include ideas around what qualifies as being included within reproductive health services. They refer to what services are ultimately available, to whom, and in what circumstances; and within what is available, what is prioritised and resourced (e.g. promotive vs preventive vs curative services; free vs paid; primary vs secondary vs tertiary; traditional vs western).

The outermost layer of De Francisco et al’s (2007) framework, within which the two inner layers, and the individuals are nested, refers to the broader political institutions, power structures, and ideologies of the society at large. Laws, public policies, population and health policies, create an environment that enable or constrain, the choices, decisions and actions of communities, families, couples, and individuals in the reproductive realm. Obviously, population and health policies and laws directly affect reproductive health. They do so, sometimes through vigorously enforced strategies and targets, sometimes against the preferences of society, and sometimes favoring the normative preferences of certain sections of society over others. They also influence the reproductive health of different individuals, differently. According to Cottingham and Myniti (2002), two public policy areas indirectly affect reproductive health. Macroeconomic policies that shape the economic opportunities and possibilities for economic security of citizens, through their influence on overall prosperity/poverty in a society, and distribution of wealth and resources across the society, influence the state of economic vulnerability/advantage of different groups of individuals; this economic vulnerability determines some individual’s ability to have a safe sex life and to make informed reproductive choices. Public policies in relation to women’s rights, that strengthen/weakens the position of women in social, economic and political spheres, influence women’s ability to exercise agency generally, and in the reproductive realm in particular. Social policies that enable girls to go to and to stay in school, that support women to work in fairly compensated jobs, which provide women equal share in inheritance and equal control over own property, which enable women to actively participate in social and political processes – strengthen the grounds on which women enter into social and economic relationships, including sexual relationships. Through influencing the community institutions and relations, and directly, these public policies influence the power women have (or not) to make choices and to take reproductive decisions, and to ultimately protect their own health.

Social norms and human behaviour: A theoretical overview

Social norms have been extensively studied in the social sciences with different disciplines having engaged with the concept from different perspectives. Sociologists have focused on the social nature and function of social norms and have studied their influence on human behaviour (Parsons 1937, Parsons and Shils 1951, Elster 1992). Anthropologists, given their
disciplinary interest in describing people and societies, have described social norms, across different social domains, in different cultures, detailing how they function (Geertz 1973). Psychologists have tried to explain why humans behave the way they do and have explored approaches to alter human behaviour. Scholarship in the field of economics, particularly experimental and behavioral economics has explored social norms within the frame of solving collective action problems (Ostrom 2000), and in relation to the influence of norms on market behaviour – prevention of market failures and cut social costs (Homans 1961).

‘Norms’ refer to group-held beliefs about how members should behave in a given context; norms are informal understandings that govern society’s behaviors. Social norms are a very powerful control upon the expression of human sexuality and reproductive behaviour. In sociology, a norm (or social norm) is a rule that is socially enforced, often informally. Social sanctioning distinguishes norms from other cultural products or social constructions, such as meaning and values. Morals, taboos, laws, and religious beliefs influence not only the sexual and reproductive behavior of individuals but also the way they perceive and describe it. ‘Preferences’ refer to an individual’s or group’s attitude towards a set of objects, typically reflected in an explicit decision-making process. ‘Expectations’ refer to what individuals and groups consider as the most likely thing to happen; people become accustomed to positive or negative life experiences which lead to favorable or unfavorable expectations of their present and near-future circumstances.

When is a norm, a norm

Generally, in the social science literature, norms are understood as external forces constraining the behavior of actors, almost always with the result that some sort of social order is produced, reproduced, or maintained. There is growing consensus that even if norms are a means to achieve some social goals, the achievement of those goals is not the reason behind the emergence or the persistence of the norm. This is exemplified by the contrarian point that many norms persist even if they are inefficient and even widely unpopular. In her book ‘The Grammar of Society: The Nature and Dynamics of Social Norms’, Bicchieri (2006) states that social norms are,

the expectations and preferences of those who follow them” [and that their very existence depends] “on a sufficient number of people believing that it exists and pertains to a given type of situation and expecting that enough other people are following it in those kinds of situations (p 2).

She argues that a rule is a social norm in a society if and only if a sufficient number of people in that population (i) know that the rule exists and (ii) prefer to conform to it, on the condition that (a) it is believed that a sufficient number of others conform to it and either (b) it is believed that a sufficient number of others expect one to conform, and might sanction one if one does not conform (p 11).
Norms and other similar social phenomenon

Elster (1989), in his book ‘The Cement of Society: A Study of Social Order’, critically examines what makes a norm social; he distinguishes between rationality and social normativity. He argues that social norms have independent motivating power; that social norms are not about self-interested rational action, but rather are original sources of actions (Elster 1989 p125). He also makes a conceptual differentiation between social norms and similar phenomena like moral and quasi-moral norms, legal norms, conventions, private self-imposed rules, tradition, habits and compulsive neuroses and similar cognitive phenomena. According to Elster, the difference between moral and social norms is that social norms are “non-consequentialist obligations or interdictions” and that moral norms do not necessarily require the presence of others to shape one’s behavior (p100). Special societal actors (judges, police) are involved in the enforcement of legal norms, and only these actors have the authority to impose formal sanctions; social norms on the other hand entail informal sanctions like shaming, avoidance or ostracism – and are imposed by ordinary people. Conventions in most societies tend to have specific outcomes as their goal, e.g. maintenance of land parcels is the purpose of inheritance related conventions; perpetuation of social differences is the purpose of marriage conventions around who can/cannot marry whom. According to Elster, conventions are often arbitrary and very often reflect the interests of powerful groups in society. The social aspect of norms separates them from private self-imposed rules (e.g. exercising; drinking alcohol; smoking). Traditions are social, but Elster distinguishes them from social norms by highlighting that they merely entail “mindlessly repeating today what the ancestors did yesterday” (p104). He argues that these phenomena, together with social norms can help explain much of human behaviour.

He explains that for,

Norms to be social, they must be (a) shared by other people and (b) partly sustained by their approval and disapproval.” [Social norms are also social] “in that other people are important for enforcing them, by expressing their approval and, especially, disapproval. (p 99).

Types of social norms: Elster’s ten categories of norms

Elster elaborates a non-exhaustive list of ten major categories of social norms (p 107-123). The first category is the one of ‘consumption norms’: social norms governing manners of dressing, carrying oneself in society, manners of speaking and addressing others, and so on. In all societies, these norms have great social significance and their violation usually leads to disapproval, censure, even avoidance, exclusion and sometimes severe punishments. The second category includes social norms about behavior which in a particular society is perceived as being ‘contrary to nature’: examples include norms around incest (almost all societies) and homosexuality (in some societies). The third category concerns social norms ‘regulating the use of money’, and perceptions in a particular society about the appropriateness of use of money in particular social situations. His examples include the presence of “norms against buying
salvation, votes, public office, spouses and exemption from military service," in most societies. The fourth category refers to social norms of ‘reciprocity’, which entail expectations that one returns favors done to us by others. For the fifth category Elster gives the example of medical ethics to refer to the non-instrumentalist and non-outcome oriented behavioral expectations that society has of certain people (doctors in his example – but could well apply to teachers, religious leaders). The sixth category of norms relates to ‘codes of honor’ societies tend to have at different points of time; these relate to norms in a particular society that ‘regulate the life of the proud man.’ The seventh category of social norms relates to the ‘systems of retribution’ and penance that different societies have; examples include instances where society assigns appropriate retribution for responsibilities for actions in which individuals are deemed to be causally involved. The eight category includes ‘work related norms’ that exist in most societies: rules that prescribe what constitutes work, that one should have an income from work and not from other arrangements, and rules that regulate what constitutes appropriate work effort. The ninth category concerns norms of ‘cooperation’ that entail expectations of cooperation irrespective of the utility and outcomes. The tenth category refers to norms of ‘distribution’ that occur across all societies, and which prescribe equality, equity, a reference-point for what is the right thing to do with the commons.

Elster’s perspective has its critics. His view that emotional states (e.g. sense of shame, sense of contempt, sense of guilt, sense of remorse) accompany and are the foundations of social norms, is considered insufficiently developed. Similarly, his views about the non-rational nature of social norms, do not hold up to the social reality of variations in social norms about the same social phenomenon. It also contradicts the social reality that norms do change (sometimes rather rapidly). Explaining changes in norms (slow changes or rapid changes alike), requires one to accept that social norms might have their origins (and maintenance) in some form of rational and cognitive processes, and that these processes might be outcome oriented. That said, analytically, the distinction he makes between rationality and social normativity, whereby social norms are understood to have independent motivating power, and not being about self-interested rational action, is an important and useful analytical distinction. Also, his clarification of what makes a norm social, and his disentanglement of social norms from others similar social phenomenon, is helpful, and is widely applied.

Distinguishing between descriptive and injunctive norms
While Elster examined normative social behaviour from a sociological perspective, Cialdini et al (1990), Reno et al (1991), Kallgren et al (2000), have examined normative social behaviour from a social psychology perspective. They argue that when studying the influence of norms on human behavior, it helps to distinguish between descriptive and injunctive norms. ‘Descriptive norms’ refer to individuals’ beliefs about the prevalence of a behavior and about what most (relevant) others do in a situation; they motivate action by informing people of what is generally seen as effective or adaptive behavior. ‘Injunctive norms’, on the other hand, refer to the extent to which individuals perceive that influential (and relevant) others expect them to behave in a certain way, and to perceive that social sanctions will be incurred if they do not. Injunctive
norms thus specify what people approve and disapprove within the culture; they motivate action by signaling social sanctions for conduct which deviates from what is approved by society. Reno, Cialdini and Kallgren (1993) discuss the importance of making explicit whether an injunctive or a descriptive social norm is at work in a particular social situation. They argue that unpacking this is central to providing a normative account of behaviour, and that it is also critical to the process of designing social interventions for behaviour change. They add that interventions that activate injunctive social norms are more likely to lead to positive behaviour change across the greatest number of settings; activating a descriptive social norm, on the other hand, is only likely to lead to socially desirable behavior in settings where most individuals already behave in a socially desirable manner. This insight has important implications for health promotion policy and practice, including but not limited to reproductive health, in the context of South Sudan. In addition to understanding what social norms govern a particular social realm, it is critical that studies reveal which amongst these norms operate injunctively, and which operate descriptively. Health promotion campaigns and strategies can then be appropriately tailored and targeted towards the appropriate audiences.

The principle of conditional conformity, and implications for norm change

In relation to norm change (and linked to it, interventions for norm change), Bicchieri adds that people have "conditional preferences for conformity to a norm" (2006 p xi). She argues that people conform to a norm on condition that they believe that both (1) others follow it and (2) they are expected by others to follow it as well. This means that, generally, actors follow social norms only when the two conditions for conformity are satisfied. Further, since social norms prescribe or proscribe behavior, they entail obligations and have accompanying expectations, and sanctions for non-conformity. Evidence shows that for certain social norms, conformity is not related to the threat of social sanctions; in fact, concerns about negative social sanctions operate as a reason for norm compliance in conditions where the social norm is not well established. Some social norms are exceptions to this conditional conformity principle if (and when) they become so well-established that the society accords a virtue status to what it prescribes, and the threat of negative social sanctions increasingly loses relevance in inducing conformity. Such norms thus lose their conditional character; others' and society's expectations to act in a certain way, are no longer contingent and open for interpretation and negotiation; instead social actors feel that they have an obligation to fulfill them.

Norms are not immutable – they change. Toury, extends the idea of the presence of competing norms regarding a matter in a society; he adds that older norms do not simply disappear, they evolve through a process of co-existence and interaction with other competing norms, actors, and societal structures. He argues that three types of competing norms operating side by side, can be distinguished – the ones that dominate the centre, the ‘mainstream’, the ‘remnants’ of previous norms, and the ‘rudiments’ of new ones, hovering at the periphery (Toury 1995 p62). These ideas of norms being conditional, and the often, concomitant presence of three types of competing norms has important implications for behaviour change interventions, including but not limited to reproductive realm, in the context of South Sudan. Studies which help understand
what competing social norms govern a particular social realm, and when different people mobilise different competing norms, and why, can provide valuable insight to guide behaviour change interventions and strategies.

*Application of these concepts in this thesis*

These understandings about social norms, how social norms shape individual action, how individuals navigate the structural influence of social norms, how social norms evolve and change, and how broader contextual influences and agency exercised by individuals interact to maintain and change social norms, inform this inquiry throughout. That social norms are contingent and open to interpretation and negotiation, and thus amenable to intervention and change, serves as the conceptual basis for arriving at the policy and practice implications in chapters 4-9. This understanding of social norms being contingent, mutable and amenable to change through contextual influences and agency exercised by individuals, reflects how structure and agency are seen to relate to each other in this inquiry. This understanding is elaborated further in the next section on the ontological and epistemological underpinnings of the study.

**Ontology and Epistemology**

For De Francisco et al’s framework (2007) to achieve its analytical potential, and for it to yield deep understanding and explanatory richness, this study is conducted in the critical realist ontological tradition. Critical realist ontology posits that the real is “whatever exists, be it natural or social” (Sayer 2000 p19), regardless of whether one can empirically access it or observe it, and irrespective of whether we happen to have an adequate understanding of its nature, including how the ‘real’ phenomenon comes to be. Critical realist epistemology posits that in-depth empirical research can help to uncover causal links which explain the relationship between observable phenomenon and the processes which generate these or change these phenomena. A positivist epistemology by contrast entails accepting what is observed and observable as fact and has the standpoint that one (can),

> Explains a fact or event (the ‘explanandum’) by showing that it followed by law of nature from a pre-existing set of circumstances or conditions. Such a showing would take the form of a deductive argument, a deduction of the explanandum from the antecedent conditions and one or more laws of nature (Lycan 2002 p409).

A realist epistemology differs from a purely positivist epistemology in that it invokes a layered or ‘depth ontology’ whereby mechanisms that generate outcomes are not always directly observable. To gain in-depth understanding and to explain the unobservable causal processes leading to the outcomes, critical realism also attempts ‘interpreting’ and expounding upon the unobservable – invoking and incorporating an interpretivist epistemology to proffer causal explanations between observable contexts and outcomes. Thus, critical realism, by not merely focusing on directly observable causal links, nor on providing a purely
constructivist, interpretivist account, is able to produce a much richer explanatory account of social phenomenon.

Two aspects of the realist approach enhance the explanatory yield of the study framework. First, the approach incorporates an explicit appreciation of the constant and dynamic interaction between the wider structural environment – referring to the concentric outer layers of De Francisco et al’s framework used in this inquiry, and agency, referring to the innermost layer within which intentional human action occurs. Secondly, the realist approach pays explicit attention to intentionality and agency of human actors (the innermost layer of De Francisco et al’s framework). The realist premise being that agents do not react to structural forces alone, but rather that they actively interpret their own structural context, attaching unique meanings to their (and other similar actor’s) situations and that agents constantly and intentionally try to re-negotiate the structural constraints in their own interests – and in the process constantly reconfigure the very structural environment that shapes their actions.

Methodologically, in critical realism, while structure and agency are looked upon as being mutually constitutive, throughout the inquiry and analysis, they are (in this inquiry) and can (in critical realism) be approached through an “analytical dualism” wherein the social-structural-cultural component and the individual/agential components are analysed separately (Archer et al 1998: 203). This methodological possibility facilitates research and enriches research yield by allowing for deeper understandings of and explanations about, how the two relate to each other and shape each other. Critical realism is compatible with a range of research methods – allowing the researcher to choose methods depending upon the subject of inquiry and what the researcher wishes to learn about it (Sayer 2000: 19). Gender and feminist research are similarly compatible with a range of research methods.

The subject of inquiry - reproductive actions and decisions, is however unique. These actions occur in a social realm where unequal and gendered power relations are enacted, very often to the detriment of the woman. While the broader frame of this inquiry is critical realism, and while it offers a robust meta toolbox for inquiry, in some ways, this toolbox is somehow insufficient for the task at hand, as it does not allow for one to sufficiently take account of the power inequalities and differences between individuals and between men and women, in the reproductive realm. This is consistent with scholars who have argued that the realist approach falls short in sufficiently taking into account inequalities and power differentials (Elder Vass 2010 p11). To overcome this epistemic limitation, this inquiry draws upon gender theory and feminist epistemology’s conceptualization of structure and agency. In critical realism, individuals are relatively autonomous causal agents who act with intention and with a purpose informed by knowledge or beliefs. This exercise of agency is however contingent upon social structures, which themselves are constantly shaped by the intentionality and actions of agents. Feminists however argue that this universal and common conceptualisation of an agent’s state of autonomy is insufficient because it does not sufficiently account for the fact that one’s position in the social hierarchy determines one’s agentic possibilities. They add that a conceptualisation of the agent, and of agency, which acknowledges social hierarchical locations and standpoints is important to be able to fully understand different facets of social reality. According to
feminist scholars, assuming a fully formed and autonomous agent and not differentiating between the agentic potentials of agents, their place in society, and their ability (or not) and freedom (or not) to act, is problematic. This is so, because doing so, ignores the myriad forms of domination and marginalisation that mark social relations (both within and between categories of agents) (Peter 2003; Barker, 2003; Connell 1987; Einspahr, 2010) – this is particularly true in the reproductive realm. They argue for an epistemology which is explicitly open to different ways of being, different ways of knowing, different ways of relating, and not merely to diverse standpoints (as is central to a critical realist epistemology). They contend it as being essential for good methodological practice (Haraway 1988). These epistemological limitations of critical realism are particularly relevant when studying the reproductive realm – a conscious effort is made to bear this in mind during the inquiry, particularly during the analysis of findings.

The gendered reproductive realm
Connell’s relational theory of gender is used to study how gendered social relations shape Fertit women’s agency in the reproductive realm. Connell (2012) conceptualizes gender as a pervasive system that structures relationships and interactions between and among men and women, shapes access to resources and status, and signifies power; she has argued for gender and health research to take a relational approach to gender. She contends that the ‘performance’ of gender by agents, involves the constant interpretation and negotiation of the meaning and expressions of gender, thereby maintaining, reproducing or transforming the social structure that shapes these relations. Connell understands gender as simultaneously involving ‘economic relations, power relations, affective relations and symbolic relations ’; the enduring patterns of these social relations being what social theory calls ‘structures’ (p 73). To fully understand how social relations, shape a particular social phenomenon or social situation, Connell makes the case for analysing the interplay between these structures — i.e. the ways they interact and shape each other, and produce social situations. Connell’s relational theory of gender focuses on social relations and their social construction as antecedents of gendering, allowing one to approach any social context openly. Further, by explicitly recognizing the historical nature of social relations it allows one to understand the meaning of gender in particular times and places. Many African gender theorists acknowledge Connell’s work as an exception to the often Western-centric and universalist theoretical perspectives on gender (Oyewumi 1998, Morrel 2016). Connell challenges the gender role theory; her central point being that gender identity is not fixed but always under construction in relation to others at the individual level, institutional level, and social level. According to Connell individuals make decisions within gender relations, and a dynamic and relational conceptualization of gender leaves room for agency. Connell reminds us that agency is not exerted in a vacuum with an unlimited number of choices, but rather that gendered social structures strongly influence individual practices. She adds that in every society, gender regimes and the gender order may constrain, or enhance, individuals’ actions and practices. And at the same time individuals, by their gender relations, might influence gender regimes and the gender order.
CHAPTER 2

REFERENCES


RESEARCH DESIGN
The conceptual and theoretical considerations discussed in Chapter 2 underpin the whole study. These considerations are reflected in the research questions too. All questions engage with the notion that exercise of agency is contingent upon social structures, and seek explanatory accounts informed by the understanding that one's position in the social hierarchy determines one's agentic possibilities. All questions, particularly RQ.3, are underpinned by the view that taking into account agent's social hierarchical locations and standpoints and recognizing that all relational arrangements in society are gendered, is important to be able to fully understand different facets of social reality. The epistemic position in all questions is explicitly open to different ways of knowing - RQs 3 & 4 uniquely reflect this position.

RESEARCH QUESTIONS

As mentioned in chapter 1, the overall research question is: How do social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit? With a view to explore in-depth how the nexus of social and cultural issues, local political and economic realities, influenced reproductive behavior, and healthcare care seeking behavior, certain focus areas were chosen for the specific research questions. These focus areas and specific research questions evolved over the study period and were refined and specified iteratively. This happened during the process of the development of the ethics submissions, during the data collection, and during the preliminary analysis. For example, the specific research question on why adolescent girls wanted to be mothers, emerged during data collection amongst adults. Similarly, the research question around the meanings connoted by male responsibility and irresponsibility in the reproductive realm, emerged during the preliminary analysis of data. These specific research questions thus focused the study on certain areas. On women's and adolescent girls’ decisions around childbearing; on women's decisions around care seeking; and, on what the articulation of men's role in these processes meant and connoted. Choosing these foci allowed the inquiry to dig deeply into and to reveal the many complex and dynamic ways in which social norms influenced reproductive and healthcare related behaviours.

The following specific research questions are answered in this thesis.

RQ.1. In what ways do social norms shape decisions around childbearing, spacing of pregnancies, and planning of families amongst the Fertit?

RQ.2. How do the gender relations and gender norms amongst the Fertit shape women's reproductive health?

RQ.3. Why do so many adolescent Fertit girls want to be mothers?

RQ.4. How may we understand the dominant narratives of male responsibility and irresponsibility in the reproductive realm?

RQ.5. Why do some Fertit women, inspite of being well aware of the benefits of modern maternity care, choose not to use available services?
CHAPTER 3

RESEARCH APPROACH

Researching reproductive decisions and actions

Researchers from the fields of demography have traditionally been at the forefront of inquiries on fertility, reproduction and reproductive health-related behaviors, choices and actions. Fertility transition theories as described by Thompson (1930), Notestien (1953) attribute fertility (decline) to changes in social life caused by industrialization and urbanization. The premise being that with these social changes, rearing of children becomes expensive enough to discourage most parents from having large families. In his influential book 'Theory of Fertility Decline', Caldwell (1982) proposed the 'wealth flow' thesis. He argued that children offer an old-age insurance policy in face of insecurity and serve as extra hands to do much of the labor-intensive domestic and subsistence work that marks poor societies. He explained fertility trends by positing that children are a valuable resource for poor people, particularly poor women for whom children are a source of prestige. His view was underpinned by the understanding that in having many children, those who are poor and are insecure, particularly the women, were making strategic and future oriented choices which have explicitly economic rationale. In taking such a view, one places reproductive actions and family formation, as being essentially about labor and productivity, and about mitigation of future, particularly old age-related risks. Caldwell’s so called ‘wealth flow’ thesis has been extensively cited and is widely used to explain reproductive behaviours and fertility trends in low and middle-income countries (Caldwell 1978, 1982). Caldwell & Caldwell (1987) in their work on the cultural context of high fertility in sub-Saharan Africa argue that those studying fertility and related decision-making in sub-Saharan African societies need to recognize that, unlike in Western and Oriental societies, in sub-Saharan Africa, the overarching emphasis in society remains on ancestry, descent and family lineage. They contend that the experience and understanding about the cost of fertility are fundamentally different, and “that high fertility does not carry economic penalties, while the foreigner’s experience has been very different” (p 410). Caldwell (2004) notes that the demographic reaction in the period following chronic conflict and insecurity involving large-scale social disruption and human loss, is a rise in fertility. Palmer (1991), building on Caldwell's thesis, concludes that in contexts of insecurity and uncertainty, where there are few possibilities to plan for a better future, “women may retreat into their traditional role of motherhood for securing labour assistance and old age support” (p 4). Caldwell’s thesis about fertility in Africa has been well established over the last two decades (Schindler & Tilman, 2011, Urdal & Che 2013).

The last few decades however show a distinct interdisciplinary turn in the approach to these inquiries. This turn was driven by a realization that the traditional, survey-based approaches in demography, while providing a robust description of the phenomenon and its proximate determinants, fell short in providing a robust explanatory account. To overcome these constraints, scholars in demography expanded upon and leveraged the explanatory resources offered by the theory of demographic transition – this allowed some population level explanations for fertility trends and patterns but fell short in providing a robust explanatory account. Other scholars drew upon theoretical and methodological resources from micro-economics and home
economics; explanations for reproductive decisions and actions were examined and proffered within a frame whereby households were assumed to be the units of production and consumption, which produced a bundle of consumer commodities — including children — all with a view to maximize household utility. These home-economics based explanatory models were thus rooted in the notion of the rational maximizing and utilitarian individual who would link fertility decisions to other household decisions, around income, consumption, division of labor, and participation in labor. These micro-economic approaches, with their utilitarian accounts of reproductive decisions and actions, however clearly fell short in sufficiently accounting for children as being about satisfying not just material, but also social, and intrinsic human and social needs. In response, scholars drew upon insights from psychology to further nuance and broaden the explanatory project around reproductive decisions and actions. According to the Hoffman & Hoffman (1973), childbearing motivation depends not merely on the economic costs of children to the household, but equally on the evaluation of the potential for fulfilment of higher social and intrinsic needs and satisfactions.

**A case for contextualizing explanatory accounts**

While these various interdisciplinary turns enriched the explanations, scholars soon realized two major shortcomings in these approaches. At one level, all these approaches assumed exercise of agency, choice and purposeful action. Social scientists, particularly sociologists, pointed out that these assumptions were problematic for a variety of reasons. They highlighted that reproductive decisions and actions were often shaped by social pressures in favor of childbearing. That these were further shaped by structural-societal restrictions on availability of and access to the means to control fertility. They argued that these volition assuming analytical and explanatory projects were only applicable to contexts where individuals and couples had strong control over both, the decision and the resources to enact the decisions. At another level and linked to the argument that analytical approaches needed to take into account the societal context, sociologists argued that for inquiries to yield policy relevant insights, it was important that explanatory accounts were contextual.

This study takes such a contextualized, interdisciplinary approach to examining reproductive decisions and actions. It does so because it helps to take into account the multi-level nature of context. It entails paying explicit attention to the context of social organization and social norms by which specific societies condone or condemn certain reproductive behaviors, and thereby shape decisions and actions of the reproductive couple. These contexts of social organization, social relations and social norms, operating through culture, religion, and politics, in conjunction with the abovementioned economic influences, normatively shape the reproductive decisions and actions, of individuals and of the reproductive couple. This approach to examining reproductive decisions and actions, was in many ways shaped by McNicoll (1980, 1985, 1994) and Greenhalgh’s (1995) work. According to them, reproductive options are limited and constrained by the social institutions and relations individuals inhabit. And that in each society, these social institutions and relations are embedded in local, historical
and yet dynamic patterns of social organization in the form of the family, community, kinship and other social relations. They highlighted that these patterns inform both the formal law and social norms. They demonstrated how these patterns shape and stratify access to social resources, opportunities for mobility, the labor market, and ultimately the relations between the state and the individual. McNicoll argued that these institutional arrangements interact to shape individual action (McNicoll 1994). Greenhalgh (1995) qualified McNicoll’s argument, by adding that individuals are not merely passive subjects of social norms, but rather are active agents, actively and constantly trying to re-negotiate the structural-institutional constraints in their own interest – and in the process constantly redefining the very structural-societal institutions and norms that shape their actions. This is also our approach to examining reproductive decisions and actions in this study.

Over the years, studies from different contexts have demonstrated the rich insight such an approach can provide. Studies from different parts of the world have shown how the reproductive couple’s decisions and actions are shaped by social norms, negotiated within gender-based power relations, and are informed by the possibilities offered within local knowledge systems and health systems (Angin & Shorter 1998; Dixon-Mueller 1993; Oppong 1995; Renne 1993; Dodoo 2006; Shiffman & del Valle 2008). This is the research approach in this thesis.

**Mobilising theory to provide a multifaceted explanatory account**

In this thesis, De Francisco et al’s framework is used primarily to guide and organise the inquiry; this transpired in two ways. The comprehensiveness of the framework ensured that the questions that were included in the topic guides were such as to allow the exploration of a wide range of possible influences on reproductive health behaviours and actions (Topic Guides are included as Annexures). The logic of De Francisco et al’s framework – that the outermost layer of societal structures and ideologies, shapes the intermediate layer of social relations which operate through social and gender norms, to influence the individual – is the overarching logic of the inquiry. The focus in this study is to unpack ‘how’ social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit. To reiterate, Cialdini’s conceptualisation that social norms are one’s beliefs about what others do and of what others approve and disapprove of, is used in this study (1990, 1991).

While collecting the data and conducting the analysis it became clear that no one theoretical perspective was sufficient to account for the multifaceted and complex nature of the ‘how and why’ dimension of the research questions and the emerging study findings. To unpack the many ways in which social norms shape action, in each chapter, I draw upon various middle range theories and concepts from different social science disciplines. These are mobilized to better understand and explain the phenomenon under study; they help shed light on, and/or help put in perspective, a unique aspect of the overall research question. That so many theoretical resources had to be mobilized to arrive at the explanatory accounts in the findings chapter, truly reflects the complexity of the phenomenon under study. Such mobilization is perhaps not the usual conventional research practice in public health. However, it is common in the social
sciences research traditions to do so – to explain the phenomenon under study, and/or to help put findings in perspective. Morse (2002) argues that good qualitative “Inquiry is not passive but active. New findings do not ‘emerge’; rather, they are derived from the inquisitive querying of every observation, of all conversations or interviews, of every implicit or overt action. These queries are not value free, nor do they extend from ignorance: They are based on wise conjecture and overt assumptions and are derived from an informed theoretical base” (p 295). Hoeyer (2008) recommends that substantive social science theories be mobilized and used as tin-openers to open up the data, and to focus and enhance its interpretation; Reeves et al (2008 p 634) add that “Different theories provide different lenses through which to analyse research problems”. Examples of different ways of such use include Totman et al’s work which (2015) drew upon theoretical insights from ‘existential psychology’ to analyse the challenges faced by home caregivers, and their interactions with healthcare professionals. Vareilles et al (2015) drew upon theories around self-determination and contingency to explain how capacity building interventions shaped the motivation, performance and well-being of health volunteers. Larsen et al (1997) used theories of feminism, gender and power to analyse interviews conducted to explore women’s experiences of pelvic examinations. Similarly, Guassora et al (2014) mobilised sociological theories about performance – the presentation of oneself as favourably as possible – to explore how social norms shaped consultations about lifestyle issues; the theoretical insights about performance helped reveal patients’ normative presentations of their self. In the following paragraphs I provide a brief account of how this is done in this thesis and of what Fig. 3.1 below, attempts to visually express.

![Figure 3.1. The research approach](image_url)
Figure 3.1 presents a diagrammatic representation of the research approach. It attempts to visualize how the conceptual and methodological understandings articulated in Chapter 2, relate to the research questions, and to each other; it indicates the key theoretical and conceptual considerations/resources that are used to explain the findings in each of Chapters 4-8 (R.Q.1-R.Q.5). In addition, the diagram seeks to depict the iterative nature of the research process.

Since the intention is to understand how social norms shape individual action – the theoretical insights about what are social norms, how individuals navigate social norms, how social norms evolve and change, and how social norms are maintained and change, serves as the conceptual canvas on which the analysis is conducted in Chapters 4-9. In Chapter 4, to answer the specific research question about the ways in which social norms shape decisions around childbearing, spacing and planning of families amongst the Fertit, theories of normative social behaviour (Gialdini et al 1990; Kallgren et al 2000) are used to explain why people do what they do. Theories of fertility and demographic change (Caldwell 1976, Caldwell & Caldwell 1987), and theories of masculinity (Connell 1995) are mobilised to put findings in a historical, demographic and relational perspective. Chapter 5 draws on Connell’s (2009) gender theory to delve deeper to unpack how gender norms and relations shape women’s reproductive health. In Chapter 6, to explain the findings around why adolescent girls want to become mothers, this analysis is extended further by drawing upon Hagan & Wheaton’s (1994) theory of life course and social roles. The works of postcolonial theorists working on women and gender studies in Africa (Sudarkasa 1996; Oyewumi 1998, 2002, 2011; Morrel 2016) helps locate and explain the findings in Chapters 4-6 (and 8) within the frames of the world that the women and adolescent girls in the study, live. Chapter 8 uses and builds upon the insights from Chapters 4-7 as the background; it examines the act of seeking care as a social act and draws upon theories on social fears (Tudor 2003) and social dignity (Jacobson 2007, 2009) to explain women’s care seeking decisions. In Chapters 7 and 8, theoretical insights around normative responsibility assignments in social relations, help explain why men and women act the way they do.

The explanatory enterprise in Chapters 4-9 is throughout rooted in critical realist epistemology; this means that theories are used to interpret, reveal, and to explain the unobservable in the data. Theory is used as tin-opener to make sense of the dynamic interaction between the wider structural environment and gendered intentional agents. This process of using theory to provide a multifaceted explanatory account was incremental and iterative. It entailed multiple deep dives into various disciplinary readings to make sense of various facets of the data – during study design, data collection, analysis and writing. Chapters 4-8, and ultimately Chapter 9 mirror both, the incremental accrual of theoretical insights, and their mobilisation to arrive at multifaceted accounts of the findings. As discussed later in the reflections section, this process is far from complete or perfect.

**Methods**

Given the research questions and given the orientation of the inquiry towards learning about how social norms shape decisions and actions, and what explains it, focus group discussions and interviews were chosen as the means for data collection.
Focus group discussions were chosen because of their proven effectiveness in exploring attitudes, opinions and values in the field of reproductive health, and the ability of focus groups to yield insight in social norms around sexual and reproductive behaviors and actions (Bender & Ewban, 1994, p. 63). While focus group discussions yield rich insight into dominant discourses on social norms, on the flip side, this is also the main limitation of the FGD – that it yields normative responses from participants (Parker, Herdt, & Carballo, 1991). Given that in FGDs, participants are articulating the normative, they often hesitate to openly share their own or to even openly discuss behaviors that are contrary to the accepted norms and values. By extension, FGDs therefore have limited yield in terms of providing insights into: explanations about deviations from the norms, strategies used by people to navigate, bypass or subvert the dominant norms, and about how and under what circumstances people use and mobilise certain norms to justify their actions in the reproductive health arena (Parker, Herdt, & Carballo 1991). These limitations of the FGD as an approach to data collection relate at a higher level to what has been called the "difficult relationship between the 'is' and the 'ought' in social action … that is, between how we actually behave and how ethical principles insist we should act” by Cohen (Cohen 2000 p 82). Such approaches may successfully elicit socially and morally prescribed principles for behaviour, they are however insufficient in providing insight into the domain of the 'real' where explanations about deviations from the dominant norms and values lie.

Focus groups discussions thus served as an entry point into people's views about what 'ought' to be and what 'ought' to be done in the reproductive realm, by different members of society. The insights from the FGDs allowed the refinement and elaboration of tools for interviews with individuals – interviews served as primary medium to gain insight into what 'is' actually done, and how people explain what is done in practice. Interviews helped to dig deep and to unpack the complex relationship between the 'is' and the 'ought' in social action.

STUDY SITES
The study was conducted in Wau County of Western Bahr el Ghazal state of South Sudan. The broader ethno-geographic and health systems context of the Western Bahr el Ghazal state has been described in Chapter 2. Two locations were selected based on homogeneity of the residents (all Fertit). Further, the locations were also such that they were within the coverage area of the health services, particularly SRH services – this was important as health service coverage (geographical) remains poor in many parts of WBeG state. Finally, the two locations represented two different settings in Wau county. One in a peri-urban part of Wau town and the other a rural area. The apriori assumption behind choosing these two locations was that perhaps within the same social group, depending on the setting, the way norms related to behavior and decisions, might be moderated differently.

SAMPLING AND RECRUITMENT OF STUDY PARTICIPANTS
Study participants included community members (adults and adolescent girls), health workers (clinical officers, nurses, health assistants, community health workers) and key informants
(traditional leaders, traditional birth attendants, state and county level SRH service managers, and NGO representatives).

**Community members**

Towards gaining answers to research questions 1, 2, 4 and 5 a sample of adults were purposefully selected as study participants. Only those community members of age 18 years and above were included in this study; we purposefully categorized participants into those between 18-35 years and those above 35 years. The assumption being that the former would be most subject to peer influences and to the norms related to sexuality and reproduction, and the latter would be the ones who would be involved in enforcing the norms, shaping preferences, setting expectations, and influencing decisions and health seeking behaviors of the former. To gain insight into research question 3 of why so many of the adolescent girls wanted to be mothers, girls and boys between 16 and 20 years of age were included as participants. Consent and participation related procedures that were followed for the involvement of those between 16 and 18 years of age are elaborated later in the chapter in the section on ethical considerations and procedures. Adolescents were purposefully selected according to criteria that were identified based on insights from earlier studies with adults. Those who were currently in union, and not currently in union, and those who were in school and not in school, were included. Amongst girls, those with children and those without children were included. Adults who were parents of adolescents were also interviewed. The participants included in the study are summarized in Table 3.1.

All community members were recruited with the help of local elders, health workers from a local non-government organisation, and the county health department. Adolescents were recruited with the help of a local youth outreach worker linked to the SHARP project, and through a snowball sampling approach. The selection and consent process for adolescents also entailed the involvement of adolescent advisors (one male and one female). These advisors were local high school/pre-university students recommended by our collaborators at the University of Bahr El Ghazal, Wau. They were briefed in detail about the study, were given an abridged study protocol and the consent forms to read and review. The adolescent advisors accompanied the study team during the process of data collection amongst adolescents.

**Health workers**

Health facility personnel working in the local health center of the study sites were also included in the study. First, an FGD was conducted to identify different aspects of the subject, and differences in views among health workers on the subject; participants included a clinical officer, 2 nurses, 1 health assistant, and 2 community health workers. The FGD was followed by SSIs with those personnel specifically responsible for reproductive health in the health center. For both, community members and health facility staff, those involved in the FGD were not involved again in the SSIs.
Key informants
In addition, key informants were purposefully selected for inclusion in the study. They were selected based on their active SRH-related role within the health system and the study community – they were identified through the initial stakeholder consultations. Key informants included traditional leaders, traditional birth attendants, state and county level SRH service managers, and NGO representatives. Given the serious shortage of health and social workers in South Sudan, the pool of managers and NGO representatives was small – in fact there was only one SRH-related officer at county and state health department level, both were interviewed. Similarly, all three NGO representatives working on SRH in Wau county were interviewed.

Table 3.1. Overview of study participants.

<table>
<thead>
<tr>
<th>Method</th>
<th>Profiles of study participants</th>
<th>Number of activities (# of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(R=Rural; P= Peri Urban)</td>
</tr>
<tr>
<td>FGD</td>
<td>Community members: Female 18-35 years (Not in union*)</td>
<td>1 (8) (P)</td>
</tr>
<tr>
<td></td>
<td>Community members: Female 18-35 years (In union)</td>
<td>1 (8) (R)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male above 35 years</td>
<td>1 (8) (R)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male 18-35 years</td>
<td>1 (8) (P)</td>
</tr>
<tr>
<td></td>
<td>Health workers</td>
<td>1 (6) (P)</td>
</tr>
<tr>
<td>SSI</td>
<td>Community member: Female 18-35 years (Not in union)</td>
<td>5 (R=2, P=3)</td>
</tr>
<tr>
<td></td>
<td>Community member: Female 18-35 years (In union)</td>
<td>6 (R=3, P=3)</td>
</tr>
<tr>
<td></td>
<td>Community member: Male 18-35 years</td>
<td>6 (R=3, P=3)</td>
</tr>
<tr>
<td></td>
<td>Community member: Female above 35 years</td>
<td>6 (R=3, P=3)</td>
</tr>
<tr>
<td></td>
<td>Community member: Male above 35 years</td>
<td>4 (R=2, P=2)</td>
</tr>
<tr>
<td></td>
<td>Community member: Parent</td>
<td>3 (P)</td>
</tr>
<tr>
<td></td>
<td>Female In School – With Child: Adolescent</td>
<td>2 (P)</td>
</tr>
<tr>
<td></td>
<td>Female In School – No Child: Adolescent</td>
<td>5 (P)</td>
</tr>
<tr>
<td></td>
<td>Female Not in School – With Child: Adolescent</td>
<td>4 (P)</td>
</tr>
<tr>
<td></td>
<td>Male In School – No Child: Adolescent</td>
<td>4 (P)</td>
</tr>
<tr>
<td></td>
<td>Male In School – With Child: Adolescent</td>
<td>2 (P)</td>
</tr>
<tr>
<td></td>
<td>Male Not In School – With Child: Adolescent</td>
<td>4 (P)</td>
</tr>
<tr>
<td>SSI with Key Informants</td>
<td>Traditional birth attendants</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Traditional leaders</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Health facility personnel</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>State SRH managers</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>NGO representatives</td>
<td>3</td>
</tr>
</tbody>
</table>

* Adult participants were either In Union or Not In Union at the time of the study; we articulate relationship status this way because in WBeG, one would publicly state one's status as married only if the relationship was formalised either in a traditional ceremony, or in the church. However, for the sake of convenience we use the terms married/unmarried in the paper.
CHAPTER 3

DATA COLLECTION PROCESSES

Data collection began with FGDs amongst adult community members. The purpose was to identify different aspects of the subject, and differences in views among participants on the subject. While the profile of the FGD participants was homogenous in terms of age and marital status, diversity was sought in terms of social and economic status (based on: social identity related inputs from elders, ownership of assets like bicycles, level of education). The FGDs were followed by semi-structured interviews (SSIs) to obtain more in-depth understanding. Amongst community members, SSIs were conducted with adults, adolescents, and those who were parents of adolescents.

Data was collected over a 2-year period from June 2014 to November 2015, over 5 visits to South Sudan. All FGD and SSIs with community members were conducted by two researchers; the local researcher led the communication and translated it for me – I also took notes. All FGDs and SSIs with health workers, SRH service managers and NGO representatives were done in English; I led these, and a colleague took notes. Similarly, I also conducted the ‘member checking’ workshop and key informant interviews. I also led and took notes from the daily debriefing sessions and discussions that were held amongst the research team members. The local research team members hailed from the study area, were fluent in the local language, and had experience with conducting qualitative research. Data was collected till saturation was reached, and no new insight emerged; this was possible to assess, as at the end of each day of data collection, the research team debriefed and discussed the emerging findings. In total five FGDs (with 38 participants) were conducted – four with community members and one with health workers. Thirty SSIs were conducted with adult community members; of which three were with adults who were parents of adolescents. Twenty-one SSIs were conducted with adolescents. Seventeen SSIs were conducted with key informants.

DATA ANALYSIS

SSIs and FGDs were digitally recorded, translated from Wau Arabic into English (where applicable) and transcribed verbatim. The translations were independently checked by one of the local investigators. Analysis of the transcripts was carried out using a comprehensive thematic matrix to facilitate the identification of common patterns and trends arising from the narratives, using NVivo 10 software. This was done in parallel and collaboratively by research team members (SK, MK, MR, EM) and emerging conceptual categories were arrived at through a process of discussion, argumentation and consensus. To ensure the credibility, transferability, dependability and confirmability of the findings emerging from this analysis, the study team returned to Wau for ‘member checking’: Findings were presented to key local stakeholders (in a workshop with 10 participants), and their reflections, and inputs were sought. A similar process was followed for follow-up interviews with key informants (n=2) and some of the study participants (n=2 in each study site). The daily debriefing sessions and insights from these interviews and workshop were also used to develop and further clarify the analysis.

Analysis was guided by the conceptual and methodological understandings articulated earlier and depicted in Figure 3.1. The data provided valuable insights into how social norms
shape the reproductive decisions and actions of the Fertit people of Wau. According to realist ontology what is real may not necessarily be empirically accessible or directly observable, one needs to attempt to interpret and expound upon the unobservable – invoking and drawing upon substantive and middle range social theories to proffer causal explanations of what is observable and how it might have come to be. Given these explanatory imperatives, throughout the analysis, insights were drawn from social science theories to provide a richer explanatory account of the observed findings. In critical realist tradition, where possible, alternative explanations were also explored and discussed.

Throughout the analysis in Chapters 4-8 and in Chapter 9, drawing on Archer’s guidance on the analytical relationship between structure and agency, efforts are made to engage with the data along two strands. On one hand, the analysis attempts to explain how social structures shape the actions and interactions of individuals. In parallel, the analysis also looks for and tries to reveal how social interactions between agents shapes the structures, both reproducing and transforming the social structures. Thus, in line with a critical realism guided analysis, structure and agency are treated as separate strata, that is, they are assumed to possess completely different properties and powers, but it is also recognised that one is essential for how the other will be molded.

ENSURING QUALITY AND ENHANCING RESEARCH RIGOR

Devers (1999), drawing on Inui & Frankel (1991), Denzin & Lincoln (1994), Creswell (1998), Patton (1999) and others, has synthesized the literature in the social sciences and health services research to discuss what entails ‘good’ practice in qualitative research. She draws broadly from the social sciences, to make a case for criteria which are different from those used for quantitative research – these are: credibility, transferability, dependability and confirmability. Devers’s (1999) synthesis provides guidance on strategies (around these four criteria) for ensuring quality and enhancing rigor when conducting qualitative research. This guidance informed the study design and all study processes. The considerations and the steps taken towards ensuring quality and enhancing research rigor for the four criteria, are summarized below.

Ensuring credibility

Views of a variety of respondents were used to gain insight into the subject of inquiry. Multiple theories were used to interrogate the data and to examine various narratives. The study team consisted of a local university faculty, an independent researcher who hailed from Wau, a highly experienced nurse from Wau, and two global health researchers from Amsterdam. All investigators were actively involved in the data collection and in the analysis; this mix added to the robust triangulation and corroboration of the findings. An explicit and ongoing focus, both during data collection, and during analysis, on disconfirming, paradoxical and counterintuitive findings, enabled the refinement and contextualization of findings. This was done through a process of argumentation and discussion: initially during the daily post-data collection debriefings, later during a data analysis workshop, and on an ongoing basis via email during the process of writing of the analysis. Finally, as indicated at the beginning of the section on
data analysis, extensive ‘member checking’ and follow-up ‘dialogue with participants,’ both with those who were involved as study subjects, and those who were not, but were knowledgeable about the subject of inquiry, ensured quality and assured the credibility of the study.

**Transferability**

Devers (1999) has argued that in qualitative research a good description of the research context not only helps assure credibility of the research results, it allows those using the research to determine whether and to what extent the findings might be transferable (or generalizable) to other settings. She adds that therefore, an important aspect of enhancing the quality and assuring transferability of research findings involves providing an account of the context and identifying those aspects of the context that are relevant to and most important for understanding the phenomenon under study. To this end, throughout the study, in the sections above, and in the findings chapters (Chapters 4-8), various aspects of the context are described. Specifically, depending on the research question at hand, accounts of the geographic, sociopolitical, socioeconomic, relational, historical, and health services context, are provided. As per Dever’s guidance, aspects of the context that are relevant to and most important for understanding the phenomenon under study, are mobilized to arrive at explanatory accounts.

**Dependability**

Devers (1999) identifies two broad approaches to ensure the dependability (reliability) of the findings. The first involves the process of conducting the research. Towards this, in line with Dever’s guidance, the study protocol and tools were reviewed by two independent ethics and scientific committees for their scientific soundness and completeness. The study protocols, data collection tools, and the field protocol were further shared with and reviewed by two local co-investigators, and by those involved in SRH service provision at the national level, and local level. On various occasions, the findings, the interpretations and conclusions were cross checked with three different individuals from the Fertit community (they were not directly involved in the study). The second broad approach to assure dependability entails peer review by critical and skeptical external reviewers. Chapters 5-9 have all been peer reviewed by multiple, external reviewers who are knowledgeable about the context, and the phenomenon under study.

**Confirmability**

According to Devers (1999), because in qualitative research the researchers are the research instrument, the onus is on the researchers to follow the processes described above – i.e. various ways of triangulating findings, seeking critical inputs from those knowledgeable about the context and the study subject, consciously identifying paradoxical/contradictory findings and engaging with them, and diligently keeping the records of the study process. As indicated above in the section on ensuring credibility, throughout the study implementation, the team of four researchers (authors SK, MK, MR and AM, the co-authors in Chapters 4-8) worked together to intensively and iteratively engage with the emerging findings. An audit trail of these processes
(travel details, stay details, email exchanges, consent forms, shared analysis files, budget trails, photographic accounts), and related institutional reporting requirements of the SHARP project, in South Sudan and Amsterdam, contribute to assuring confirmability of the research.

**ETHICAL CONSIDERATIONS**

This research was approved by the Independent Ethics Committees of Ministry of Health, Government of South Sudan, Juba, South Sudan, and KIT Royal Tropical Institute, Amsterdam, the Netherlands. The approval letters are included in the annexures. Administrative approvals were granted by Department of reproductive Health, Ministry of Health, Government of South Sudan, Juba, South Sudan; State Ministry of Health, Western Bahr el Ghazal State, Wau, South Sudan.

**Consequences for community members**

FGDs and SSIs with community members took place at locations preferred by the study participants. It was realised that given the sensitive nature of some of the topic matters, some lines of enquiry during FGDs and SSIs might be regarded as intrusive and too personal. We were conscious that when researching the expectations from health services and perceptions related to health service delivery, one must remain cognizant of the power relations between providers and service users. This together with the sensitive nature of the information to be gathered, protecting and respecting the privacy and confidentiality of participants was a critical consideration throughout the study; the steps taken to ensure this, during data collection, data analysis and more generally, are described in the section on 'privacy and confidentiality' below. Similarly, careful steps were taken to minimize potential distress to study participants. All tools were reviewed by researchers who were familiar with the local mores and social conventions. After each interview, the study team debriefed to identify areas for improvement, being particularly alert to any counselling needs that could emerge as a result of being involved in the study processes (consent, interviews, focus groups discussions). Details of the measures taken to address these needs are presented in the section on social and cultural sensitivity below.

**Informed consent**

Study participants were provided with information about the study before any consent to participate was sought. Study participants were informed of the aims, and anticipated benefits and potential risks of the study and only then were offered the possibility to take part in the study. Participants were also informed about the institutional affiliations of the researchers, their right to abstain from participating in the study, or to withdraw from it at any time, without reprisal, and of the measures to ensure confidentiality of information provided. This was always done before the interview/FGD commenced. For those who could read, the consent form was given to them and read out to them to seek both their written and oral consent. For those who could not read and write, after initial explanation of the study, the consent form was read out, and oral consent was sought – consent was audio recorded, and a thumb impression was taken.
on the consent form. This process was applied to adults and adolescents alike. The interviewers and FGD facilitators were well-versed in ethically gaining consent and using the consent forms.

Informed consent from adolescents was guided by WHO’s guidance that “where adolescents are or are about to be sexually active, investigators commit no legal offence in undertaking research that promises a favorable benefit-risk ratio”, and “If adolescents are mature enough to understand the purpose of the proposed study and the involvement requested, then they are mature enough to consent” (Ruiz-Canela et al 2013, WHO Undated). It was also guided by Bruzzesse et al’s (2003) recommendation that unlike younger adolescents, those over 16 can make informed decisions as well as adults, was brought to the attention of the ethics committee. Based on the guidance of the ethics committee two local adolescents (1 male and 1 female) were engaged as adolescent advisors. These advisors were responsible for explaining the purpose of the study to adolescents before the consent process. Only those who would express interest (to the adolescent advisor) in participating were brought in contact with the research team. The research team would then again explain the purpose of the proposed study and the involvement requested; if the researcher felt that the purpose was understood, then the written consent was sought.

Communities in Western Bahr el Ghazal have a fair amount of experience with dealing with NGOs who provide the bulk of health and social services – almost always through a project approach (which often entails baseline and endline assessments with beneficiary communities). The situation analysis that preceded the project (and this study) indicated that in Western Bahr el Ghazal, people do not hesitate to talk and are open to talk about their culture, expectations and preferences. This was confirmed by the overwhelming interest and open interaction we encountered during data collection. Access was further facilitated by the fact that many members of the research team were Fertit themselves – this was an important source of reassurance to informants given the tense ethnic relations in South Sudan.

**Reflections on potential hidden constraints to consent**

There was always a possibility that community members and other possible study participants felt obliged to participate, as they might feel that their interaction with health service providers could be compromised if they do not consent to participate in the study. During the process of obtaining consent, this possibility was openly discussed with the participants – participants were explicitly assured that participation was voluntary and that, if they chose not to participate, they would still continue to get the usual health care and services. It was highlighted that the research team was independent of the public health services of Western Bahr el Ghazal state. Many of the team members being foreigners, and having collaborators from the local University of Bahr el Ghazal, helped us make this case in a credible manner.

**Reflections on the effects of the research on local health services**

The research team coordinated the field work with the managers of local health facilities. Interviews and FGDs with health staff were managed in such a way as to minimize effects on
health service delivery. For example, we interviewed facility staff either before or after they had finished their care provision tasks. Data collection activities were coordinated such that health workers and/or managers would not need to disrupt their duties. Interviews at/around health facilities were done such as to not interrupt service delivery either. FGDs and SSIs with community members were conducted in the community – in schools, under trees, in homes – depending on what individuals and groups preferred.

**Social and cultural sensitivity**

Reproductive health related norms, preferences and practices are sensitive social and cultural issues. To facilitate open dialogue, male and female study respondents were included in separate FGDs. Furthermore, male study respondents were interviewed by male researchers and female study respondents were interviewed by female researchers. Throughout the study we remained aware of the possibility that some of the study participants might have witnessed or experienced violence, including sexual violence. To ensure support, a trained counsellor was available to provide professional help; all participants were explained about the availability of these counselling services as part of the consent process. No such situation requiring counselling emerged during the study. However, there were many instances where people in the community sought help in getting treatment for individuals, and this was provided (for example, on two occasions, the research team took along with them in their car a child and his mother to the state hospital for further treatment).

**Privacy and confidentiality**

Robust methods and procedural measures were adopted in relation to matters such as data recording style, personal identifiers, transcription and processing procedures, lifespan of unprocessed data, type and places of storage, and data safety and right of access. Specifically, all data were kept separate from identifying information and files were stored under locked folders. Access to data was strictly limited to the research team. Following steps were taken to ensure privacy and confidentiality:

- Data collection was always conducted in a place/space that was private and comfortable for the participants. Steps were taken to not compromise the privacy of study participants.

- Data handling guidelines of KIT ethics committee were followed to minimise risk of accidental disclosure. These included actions to protect data from unauthorised third parties, including safe storage of hard and soft files, notes and tapes; and removal of personal identifiers from files before analysis to ensure anonymity of the respondent. Consent forms which identified the study participant were stored in a secure cabinet at KIT in Amsterdam. Only the principal investigator had access to the keys.

- Digital recordings were destroyed after data had been transcribed, independently checked and anonymized. The document with details of the anonymization was also stored in a secure cabinet at KIT in Amsterdam.
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FINDINGS:
SOCIAL NORMS AND FAMILY PLANNING DECISIONS IN SOUTH SUDAN
CHAPTER 4

ABSTRACT

Background
With a maternal mortality ratio of 789 per 100,000 live births, and a contraceptive prevalence rate of 4.7%, South Sudan has one of the worst reproductive health situations in the world. Understanding the social norms around sexuality and reproduction, across different ethnic groups, is key to developing and implementing locally appropriate public health responses.

Methods
A qualitative study was conducted in the state of Western Bahr el Ghazal (WBeG) in South Sudan to explore the social norms shaping decisions about family planning among the Fertit community. Data were collected through five focus group discussions and 44 semi-structured interviews conducted with purposefully selected community members and health personnel.

Results
Among the Fertit community, the social norm which expects people to have as many children as possible remains well established. It is, however, under competitive pressure from the existing norm which makes spacing of pregnancies socially desirable. Young Fertit women are increasingly, either covertly or overtly, making family planning decisions themselves; with resistance from some menfolk, but also support from others. The social norm of having as many children as possible is also under competitive pressure from the emerging norm that equates taking good care of one’s children with providing them with a good education. The return of peace and stability in South Sudan, and people's aspirations for freedom and a better life, is creating opportunities for men and women to challenge and subvert existing social norms, including but not limited to those affecting reproductive health, for the better.

Conclusions
The sexual and reproductive health programmes in WBeG should work with and leverage existing and emerging social norms on spacing in their health promotion activities. Campaigns should focus on promoting a family ideal in which children become the object of parental investment, rather than labour to till the land — instead of focusing directly or solely on reducing family size. The conditions are right in WBeG and in South Sudan for public health programmes to intervene to trigger social change on matters related to sexual and reproductive health; this window of opportunity should be leveraged to achieve sustainable change.

BACKGROUND

After a long civil war (1955–2005), South Sudan became an independent country in July 2011. The war has destroyed much of the public infrastructure, and economic activities and opportunities are few. The newfound freedom and peace have been regularly disrupted by violent civil conflict in some parts of the country. The health care system is also weak, with severe shortages of health workers and functioning health facilities (MOH 2012, Mugo 2015). As a result, South Sudan has one of the world’s worst population health indicators; this is particularly so for sexual and reproductive health (SRH). For instance, at 789 deaths per 100,000 live births, it has one of the highest maternal mortality ratios (MMR) in the world (WHO 2015); similarly, the contraceptive prevalence rate (CPR) is just 4.7%, with only 1.7% of women reporting using modern methods (MOH 2011, SSCCEC 2010). While reliable data disaggregated by state and ethnic group are not available, it is reasonable to expect that, minor differences notwithstanding, the situation is similar in all 28 states. South Sudan’s SRH challenges relate both to the supply and demand sides of SRH services.

In this context, and with the purpose of informing the development of a locally appropriate intervention approach, a study was conducted to explore factors influencing SRH-related behaviours and decision-making on a range of SRH issues, including ‘family planning’, in Western Bahr el Ghazal (WBeG) state. Evidence (Ahmed 2012) shows that increased contraceptive use alone has “cut the number of maternal deaths in developing countries by about 40% over the past 20 years” (Cleland 2012). Since 2011, unlike some other parts of South Sudan, WBeG has been relatively peaceful, and at the time of the study, some forms of basic health and reproductive health services, including modern contraceptives, were generally available across the state. Thus, demand-side, population-level factors are perhaps as important as the supply-side factors for the low CPR in WBeG.

South Sudan is home to more than 50 ethnic groups; at the national level, the Dinka and the Nuer constitute the biggest ethnic groups. While they constitute a sizeable part of the population in South Sudan, in some states other ethnic groups tend to predominate. For instance, in WBeG, the three main ethnic groups are the Fertit, Luo (or Jur) and Dinka; the Fertit, a moniker used to refer to a loose conglomeration of more than 23 non-Dinka, non-Arab, non-Fur and non-Luo people, are the predominant group (Personal Accounts). Unlike the Dinka and the Nuer, who are pastoralists, the Fertit are predominantly agriculturist people involved in subsistence farming. The Fertit, like all other South Sudanese ethnic groups, are patriarchal; men have the power to decide on all aspects of the family and in society at large, and women’s position is subordinate to men (Scott 2013, Bior 2013, Scott 2014). Edwards (2014) argues that a range of societal, historical and political processes have led to a situation where gender inequalities in South Sudanese society have become entrenched and disadvantage women in social, economic and political realms alike.

No matter where one is, planning a family is a complex process, with the couple’s decisions regarding family size, timing of pregnancy/spacing and contraceptive use affected by a variety of factors. According to de Francisco et al.’s (2007) conceptual framework, a range of interlinking
factors in the household, community, larger society and the political environment shape the SRH related decisions and actions of individuals; these factors also shape the consequences experienced by individuals of their decisions and actions. According to the framework, the intimate, family and social relations, including intra/inter-generational relations and gender relations, shape individuals’ ability to make SRH related decisions. These close interpersonal relationships are set within an intermediate circle of kinship structures and community institutions, which are, in turn, nested in an outer circle of national political and social institutions, power structures and ideologies. Within these overlapping spheres of influence, individuals and social groups occupy positions of relative advantage or disadvantage with respect to their access to information and other resources — including their capacity to make decisions; this has important implications for their own and others’ SRH and rights. A wide range of influences shape both behaviour and opportunities, with consequences for SRH-related behaviours (decisions and actions); they point out that these influences are transmitted through community-level institutions. For instance, the meaning and value given to what constitutes sexual health, reproductive health, satisfaction, distress, motherhood and fatherhood is always strongly influenced by dominant cultural norms. Similarly, social norms also create powerful ideals of manhood, womanhood, masculinity and femininity, and they define what sexual and reproductive behaviour is appropriate for men and for women, at different stages of life. Social norms condemn or condone SRH-related behaviours, expectations and decision-making processes; they also define access to resources and information, which together are necessary for decision-making related to health (including SRH).

While factors influencing SRH-related behaviours and decisions include both those related to availability and access to services and social- and individual-level factors, the focus of this paper is on the latter. The paper provides insight into how social norms shape behaviours and decisions related to family planning among the Fertit people in WBeG. Such insight can be useful for public health policymakers and programmers in WBeG for designing and implementing locally appropriate and culturally sensitive SRH interventions; this insight can also be valuable for other states in South Sudan with similar, large agriculturist communities.

**METHODS**

A qualitative exploratory study was conducted. Data were collected through focus group discussions (FGDs) and semi-structured interviews (SSIs) conducted with a variety of purposefully selected informants, as detailed in Table 4.1. The following sections further explain the sampling and recruitment principles and processes.

Topic guides for FGDs and SSIs were developed using de Francisco et al.’s (2007) conceptual framework. The topic guides included questions exploring social norms and beliefs about sex, sexuality, roles and relations between men and women, reproduction, and what shapes the decision-making on matters related to reproduction. The topic guides also included questions about preferences and expectations from, and views about, current SRH services. The topic guides for health and other workers included questions along the same lines, but
with a view to exploring the situation from their perspective. The FGD and SSI topic guides for community members were prepared in English and translated into Wau Arabic (by investigators MR and AM). The topic guides were defined further during the initial stakeholder workshops, pre-tested in the study site and also adapted iteratively as the study progressed. The FGDs and SSIs with community members were conducted in Wau Arabic, a language spoken by all around Wau, including the Fertit people; interviews with health and other workers were conducted in Wau Arabic or English, depending on the preference of the health worker.

The analytical framework provided by the theory of planned behaviour (TPB) (Ajzen 1991, Ajzen 2002) was used to critically analyse factors shaping behaviour and decision-making related to family planning among the Fertit people in WBeG. According to TPB, three major antecedent domains influence a person’s intention to perform a behavior: 1) attitude towards and belief that performing the behaviour will lead to the desired outcomes; 2) social norms related to the behavior; and 3) one's perceived control over or perceived ability to perform the specified behaviour. The TPB contends that a positive attitude and positive outcome expectations alone are not enough to shape decisions and behaviour; the two domains, the prevalent social norms and one’s beliefs about own ability and capacity to act, also operate concomitantly to affect individuals’ decisions and actions. The TPB is a mid-range theory which has been widely used and is well suited to describe the antecedents of particular behavioural intentions (Ajzen 2001).

Table 4.1. Overview of study participants and data collection.

<table>
<thead>
<tr>
<th>Method</th>
<th>Profiles of study participants</th>
<th>Number of activities (number of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Community members: Female 18-35 years (Not in union*)</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Community members: Female 18-35 years (In union)</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male above 35 years</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male 18-35 years</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Health workers</td>
<td>1 (6)</td>
</tr>
<tr>
<td>SSI</td>
<td>Community member: Female 18-35 years (Not in union)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Community member: Female 18-35 years (In union)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community member: Male 18-35 years</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community member: Female above 35 years</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community member: Male above 35 years</td>
<td>4</td>
</tr>
<tr>
<td>SSI with Key Informants</td>
<td>Traditional birth attendants</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Traditional leaders</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Health facility personnel</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>State SRH managers</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>NGO representatives</td>
<td>3</td>
</tr>
</tbody>
</table>

* Participants were either In Union or Not In Union at the time of the study; we articulate relationship status this way because in WBeG, one would publicly state one’s status as married only if the relationship was formalised either in a traditional ceremony, or in the church. However, for the sake of convenience we use the terms married/unmarried in the paper.
Recognizing that in many situations individuals and groups defy what appear to be strong social norms (Rimal 2005), and that norms both shape actions of agents and are at the same time themselves being constantly shaped by these actions, we draw on the critical realist explanatory tradition to go one step further to discuss and explain norm congruence, norm defiance and, thereby, norm maintenance or transformation (Archer 1998). To do so, we draw on Archer (1998, Ch 14, p20), who argues for an analysis which approaches structure and agency through “analytical dualism”, wherein “the structural, cultural and agential components are analyzed separately, with a focus on their logical relations and the conditions and possibilities that these allow”. The analytical emphasis is thus twofold: explaining how the social structures shape the actions and interactions of individuals, and how at the same time the social interactions between agents also shape the social structures and social relations, both maintaining or reproducing and transforming them.

**Study sites**

The study was conducted in Wau county in the state of WBBeG in South Sudan. Two locations were selected based on the homogeneity of the residents (all Fertit). Further, the locations were also within the coverage area of health services, particularly SRH services. This was important, as the geographical coverage of health services remains poor in many parts of WBBeG. Finally, the two locations represented two different settings in Wau county: one in Wau town and the other a rural area. The *a priori* assumption behind choosing these two locations was that perhaps within the same social group the way norms related to behaviour and decisions might be moderated differently in different settings.

**Sampling, recruitment of study participants and data collection**

The main categories of study participants are summarized in Table 4.1. Community members were purposefully selected with the help of village elders, health workers from a local non-governmental organization (NGO) and the county health department. Among community members, only those aged 18 years and above were included in this study; a separate but linked study has been conducted among adolescents. We purposefully categorized participants into those between 18 and 35 years and those above 35 years — the assumption being that the former would be more subject to the norms related to sexuality and reproduction, and the latter would be the ones involved in enforcing the norms, shaping preferences, setting expectations and influencing the decision-making and health-seeking behaviours of the former.

Data collection began with FGDs among community members to identify different aspects of the subject, and differences in views among participants on the subject. This was followed by SSIs to obtain more in-depth understanding. For FGDs with community members, participants were homogenous in terms of age and marital status, yet diversity was sought in terms of social and economic status (based on: inputs from elders related to social identity, ownership of assets such as bicycles, level of education). FGD participants were not involved in the SSIs.

Health facility personnel working in the local health centre of the study sites were included in the study. First, an FGD was conducted to identify different aspects of the subject, and
differences in views among health workers on the subject. Participants included a clinical officer, two nurses, a health assistant and two community health workers. The FGD was followed by SSIs with those personnel specifically responsible for reproductive health at the health centre. FGD participants were not involved in the SSIs.

Key informants were also purposefully selected for inclusion in the study; they were selected based on their active SRH-related role within the health system and the study community and identified through the initial stakeholder consultations. Key informants included traditional leaders, traditional birth attendants, state- and county-level SRH service managers and NGO representatives. Given the serious shortage of health and social workers in South Sudan, the pool of managers and NGO representatives was small — in fact there was only one SRH-related officer at both county and state health department level, and both were interviewed. Similarly, all three NGO representatives working on SRH in Wau county were interviewed.

Data were collected between October 2014 and April 2015, from three visits to Wau. FGDs and SSIs with community members, traditional leaders and traditional birth attendants were conducted by research team members who hailed from the study area, were fluent in the local language and had experience in conducting qualitative research; interviewers and participants were matched by sex. FGDs and SSIs with health workers, managers and NGO representatives were done in English. Data were collected until data saturation was reached and no new insight emerged; this was possible to assess, as at the end of each day of data collection, the research team debriefed and discussed the emerging findings. In total, 5 FGDs (with 38 participants) and 44 SSIs were conducted. This is congruent with the general experience on saturation; according to Creswell (1998), a sample size of around 30–50 is generally sufficient to achieve saturation in a qualitative study.

Data analysis
SSIs and FGDs were digitally recorded, translated from Wau Arabic into English (where applicable) and transcribed verbatim; the translations were independently checked. Analysis of the transcripts was carried out using a comprehensive thematic matrix to facilitate the identification of common patterns and trends arising from the narratives, using NVivo 10 software. This was done in parallel by three researchers (SK, MK, MR), and emergent conceptual categories were arrived at through a process of argumentation and consensus. Validity of findings and of the analysis was further assured through a data validation workshop (n=10) and interviews with key informants (n=2), and also through follow-up interviews with some (n=4) of the study participants in both study sites. The daily debriefing sessions and insights from these validation interviews and workshop were also used to develop and further clarify emerging analytical themes.

ETHICAL CONSIDERATIONS
The study was approved by the Independent Ethics Committees of KIT Royal Tropical Institute, Amsterdam, and the national Ministry of Health of the Government of South Sudan. Administrative approval was given by the WBeG Ministry of Health. Informed consent was
taken from all participants. Consent was sought only after the person had been contacted to participate (and had in principle agreed), but before any of the interview questions were asked. For those who could read, the consent form was given to them and also read out to them to seek both their written and oral consent. For those who could not read, the consent form was read out to them, and their consent was recorded. Confidentiality was maintained throughout, and steps were taken to anonymize the data and to minimize risk of accidental disclosure and access by unauthorized third parties.

Sex, sexuality and reproduction are sensitive, intimate and yet social issues. At the beginning of the consent process, participants were informed of their right to refuse to answer any questions they might find intrusive. The interviewers were also very conscious of this and did not press ahead with a line of inquiry if they noticed the participant was not comfortable. Furthermore, given the sensitive nature of the topic, there is a risk of opening up hitherto closed, yet painful chapters and experiences in the person's life. To ensure support if such a situation arose, a trained counsellor was available, as were medical referral services. No such situation requiring counselling or medical referral emerged during data collection. However, there were many instances of people in the community seeking help to get treatment for individuals, and this was provided — for example, on two occasions, the research team used its car to take a child and his mother to the state hospital for further treatment.

RESULTS

Findings are presented along three broad lines: knowledge of and attitudes to pregnancy, family planning and contraceptive use; social norms shaping family planning decisions; and participants' perceived control over or perceived ability to make reproductive decisions and choices.

Knowledge of and attitudes to pregnancy, family planning and contraceptives

Childbearing as God's will and one's duty

Both Fertit women and men consider having children very important. Getting pregnant after marriage was looked on positively, and a common belief across sexes and across age groups is that pregnancy is 'God's will':

Pregnancy is of course from God … pregnancy is from God. (B FGD M under 35)

Once you get married … if God wills you give birth right away as that is the main reason. (FGD Males over 35)

Only one of my three daughters have no child. Only one … God did not give her a child. (FGD Females over 35)
Another related view shared by men and women alike, albeit perhaps more so by the older generation, was that it was desirable to have as many children as possible — that it was a woman’s duty to bear children:

Our community believes that bearing a child is from God. If God gives you strength to give birth to 10 or 12 you will be lucky. (Traditional Leader)

**Spacing pregnancies, the right thing to do?**

All respondents recognized that a sufficient amount of time was necessary between two pregnancies and had a favourable view of spacing. They believed this for many reasons; a common belief among women was that getting pregnant immediately after delivery was bad for the unborn child:

... When a woman gives birth and before her baby sits she is pregnant again this is when you harm your small baby... (Female over 35)

Another belief was that having frequent pregnancies was bad for the woman’s health,

And when it is frequent it will affect the uterus and the pelvis will be tired. (Female Married under 35)

Housework and food also will be difficult. If a woman gives birth every year it wears her out. (FGD Females Married under 35)

Men, both young and old, also knew about the importance of spacing; their arguments, however, tended to be more related to the negative effect of frequent pregnancies on the recently born child or on the yet unborn child. In an FGD some older men pointed out, perhaps referring to a local belief, that getting the wife pregnant again before the first child has started walking was detrimental to the health of the unborn child. As the following quotes illustrate, this understanding and a favourable attitude to spacing was shared by the younger men:

From the time your wife delivers a baby and when it starts walking, then you can go on top of his/her mother again so that you can bring another child. But if the child born is not yet walking, if you get on top of his/her mother, that child will be paralyzed. (FGD Males over 35)

Sometimes if there is a baby in the stomach and there is [already] a [breastfeeding] child, the [unborn] child can get dehydrated in relation to the child’s breastfeeding …
the [unborn] child will be … sometimes you will find a child like this hand of mine … will be very skinny… (FGD Males under 35)

Men and women pointed out how this understanding about the importance of spacing was part of their traditional knowledge about pregnancy; a traditional leader echoed this thus:

For our old generation we used to wait even after two years… Our traditions are against that [back-to-back pregnancies]. (Traditional Leader)

Some older women argued that the times were harder now, that raising children was more difficult now, and that this made it necessary for women to space pregnancies:

Child delivery in the past is not like the present. If you bear ten children, where will they get education…? This is not good. It is better to bear children and have gaps between them so that they can get good education. But if you have ten, nine, five children, there will be many, and raising them becomes very difficult. (FGD Females over 35)

Others disagreed, pointing out that because childbearing was God’s will, one could not say how many children one should have,

Childbirth is from God. I cannot say they should have these many children… I don’t like it; I think it is very bad. How can they stop a woman from having a child? God has given that to you. Are they going to stop it? (FGD Female over 35)

Younger women also had some misgivings; for instance, during an FGD among younger women, there was much agreement when one of the participants said that if a woman does not have a child for three or four years, it can make subsequent deliveries more difficult. A discussion among younger women during an FGD went as follows,

If you stay long without getting pregnant it becomes hard, so three years is reasonable… Four years is too long, and some places will be tight, and it puts women in a dangerous situation … So, three years is reasonable. (FGD Females Married under 35).

The use of contraceptives
As the following quotes illustrate, younger women, unlike other informants, had a uniformly favourable attitude towards using contraceptives, perhaps reflecting a more pragmatic understanding of the situation. They not only know about modern contraceptive options but also
commonly use them, although some women mentioned they had stopped using contraceptives after experiencing negative physical effects,

Facilitator: Do you know how to plan your family?  
Respondent: Family planning is like taking pills every morning. These pills are given. If you go to the health centre and you say that you want to plan pregnancy, they give you pills ... if the injection does not suit you. There is an injection given for up to six months. So, you need to plan pregnancy. (Female Married under 35)

Contraceptive pills are very good if you can tolerate it. I tried contraceptive pills before and I used to see my menses twice a month. This is why I stopped it. (Female Unmarried under 35)

While all recognized the importance of spacing, and were knowledgeable about modern contraceptive options, there were disagreements about their use. Men were mixed in their views about women using contraceptives to space pregnancies. While some took a more pragmatic view, others, including some younger men, strongly disapproved,

For younger girls who had children early and do not want to become pregnant again, the doctor can offer contraceptive pills ... The woman can be given injections or contraceptive pills to prevent pregnancy, and young girls can go back to school. (Male Married over 35)

Those condoms, those pills, those injections. Our fathers in the past didn't do it. For what reason should we come to do it? Does it mean that we alone do not know how to plan a family? My wife is not going to swallow pills or get injection ... for what? (FGD Males Married over 35)

Many men were concerned about women going behind their backs and using contraceptives, particularly the long-acting injectables; while not explicit, there was insinuation that the health services were somehow abetting this. They argued that it was because of this trend that some men were forbidding their wives to use modern contraceptives:

Some women do it in agreement with their husbands; others just go to pharmacies on their own and buy the pills and use it without telling their husbands ... the men do not know what the woman is doing; they have no ideas about such things. Such men think it is God who has not blessed them with another baby. (Male Married under 35)

Health facility personnel shared concerns regarding how some men perceived the promotion of contraception — as attempts by outsiders to deny them their right to have many children,
as outsiders were the ones promoting contraceptive use. The following quote highlights the importance of handling delicately any intervention to promote contraceptive use.

... Let the youth give birth because a long time ago we gave birth too, and they would say you are denying their children to have children... They say before we used to give birth, why now does the white man want our girls not to give birth? (FGD Health Personnel)

In one of the FGDs, young women recognized that many men had a suspicious attitude towards the health services. They agreed that this was not the right thing to do and that such a situation would make things difficult for everyone,

Family planning is good, but ... planning should be done after you agree with your husband. You tell him that life is difficult ... other women just go and start family planning without involving their husband, and then it causes problems in the house; the woman stops the planning, and then she starts giving birth one after the other. So, this is a mistake. (FGD Females Married under 35)

Social norms on childbearing, spacing and contraceptive use

The theory of planned behaviour refers to social norms as structural powers which shape people’s intentions and behaviour. Cialdini et al. (1990) and others (Kallgren 2000_ argue that when studying the influence of norms on human behaviour, it helps to try to distinguish between descriptive and injunctive norms, even if sometimes it is empirically difficult. Descriptive norms refer to individuals’ beliefs about the prevalence of a particular behaviour and about what most (relevant) others do in a particular situation. Injunctive norms, on the other hand, refer to the extent to which individuals perceive that influential (and relevant) others expect them to behave in a certain way, and to perceive that social sanctions will be incurred if they do not. This section presents findings on how social norms, both injunctive and descriptive, shape the Fertit people’s intentions and behaviours about spacing and contraceptive use.

Social norms on marriage and childbearing

Among the Fertit (and most ethic groups in South Sudan), the injunctive social norm around marriage is that a man marries a woman to be able to bear children, to replace dead family members. There is social pressure on women to bear children, and not bearing children incurs social disapproval, even ostracism.

The community is the main reason for all this, especially neighbours, friends and parents. They complain a lot that their son needs to have babies to replace a dead uncle or a dead grandfather, so they want him to name relatives who passed away. (Health Personnel)
Yes, they insist on what they are doing. Regarding family planning, some say I married this woman ... why shouldn’t she give birth. This woman must give birth and not take any contraceptives. (NGO)

As the following interaction during an interview with a young man illustrates, it is normative that women have children, and that asking a wife to stop is just not done,

Facilitator: Are you married? Respondent: Yes. Facilitator: Did you ever think, or did you ever ask your wife not to become pregnant? Respondent: No, I have never done that. Facilitator: Why? Respondent: I have never thought about that before. (Male Married under 35)

Our community does not encourage spacing children. (Male under 35)

In fact, the social norm is that if a woman does not bear children, then she, as the quote below illustrates, is considered not worth keeping. Further, men are also normatively expected to have multiple children. Those who do not continue to father children run the risk of being labelled as infertile and subjected to ridicule; they also risk their wives leaving them for other men.

If the wife just stays for six months without getting pregnant, immediately they start asking ‘Was she brought just to go to the toilet, and who is to pay for that?’. (Health Personnel)

Facilitator: What does the community say about a family where the woman does not become pregnant for a while? Respondent: The community does not speak well about that. They will say that the woman is not fertile, and the man is wasting his time. He should go and find another woman who can bear him some children. Sometimes the woman’s family will say that the man is infertile, and their daughter needs to find another man. Some of them will start having an affair. (Male Married under 35)

Thus, injunctive social norms on marriage and childbearing have a major influence on the intentions and behaviours of men, women and couples about spacing and contraceptive use.

Social norms on spacing
In Fertit society, there is an injunctive social norm that women should get rest after each pregnancy. As the following quote from an older woman illustrates, while having many children is desirable and expected, both at the societal and the individual level, women and men reported
that in society it is frowned upon if a woman in the family becomes pregnant very soon after childbirth:

When a woman gives birth and two months later she gets pregnant again, it is shameful. All your family, even your own mother, will be blamed, because they will say why did you let this girl get pregnant and her baby is still small. It is a bad reputation in the family. (Female over 35)

One traditional leader highlighted the social sanctions in the form of shaming of the family and the woman if a baby were to be born with a low birthweight because of insufficient spacing:

Our traditions are against that [back-to-back pregnancies]; if a woman gives birth to an immature child [with low birthweight], she will be called ‘Na-Ngoyo’ … means the mother of an immature child. It is a shame in our community. (Traditional Leader)

It was also clear that there were no injunctive social norms which explicitly or implicitly sanctioned the use of modern contraceptives:

Facilitator: So there are no traditions that prohibit contraceptives? Respondent: No. If you go for an injection, it is up to you …. (Female Unmarried under 35)

You from your own will and the will of your wife. If you see this woman having [multiple and frequent] childbirths, like for me, maybe I will go to the doctor to give us family planning. (FGD Males under 35)

Men and women relied on the actions and experiences of important others (descriptive norms) to inform their own intentions and actions; the important others influencing contraceptive decisions and choice included family and close friends, and the traditional leaders. Women’s attitudes to different forms of modern contraceptives were informed by experiences of friends and family members:

This issue of contraception … even me, I wanted it. I have my sister-in-law who has an IUD inserted, and it is giving her a hard time: every month she bleeds a lot. So, I decided not to take anything and just save myself and pray to God to save me. (Female over 35)
Ability to act and decide

Kabeer (1999), in her influential work on women's empowerment, frames women's “ability to define one's goals and act upon them” as their ‘agency’. Agency is exercised in relation to others; as Kabeer explains, it is “more than about just observable action” and includes the ability to negotiate and bargain, subvert, resist and manipulate, and also more intangible cognitive processes of reflection and analysis (1999: p 438). This section shows how Fertit women's ability to decide about their pregnancies and spacing of pregnancies is constrained. It also shows how they are using the opportunities available to them to subvert and resist and overcome these constraints — a testimony to the dynamic and relational nature of human agency and how it also shapes social norms.

Entrenched patriarchy and women’s constrained agency

Women consistently referred to ‘abstinence’ after delivery as the way to avoid getting pregnant soon after; in an FGD among married young women, the respondents explained how they went about getting their husbands to cooperate — a poignant reflection of the severely constrained nature of women's agency and of their resigned attitude to the social acceptance of their husbands having sex outside their marriage, despite being well aware of the risks of contracting sexually transmitted infections:

If you have a three-month-old baby and your husband goes and finds another chance, let him go. Tell him to find someone who will not bring us disease and who will join me, and we talk and laugh. In this way, your baby will not suffer. (FGD Females Unmarried under 35)

You will stay away from the husband a bit. You can allow your husband to go around like when you have a child in your hand. (FGD Females Married under 35)

Entrenched patriarchy among the Fertit bestows on men the status of the head and the sole decision-maker of the household; not only do the men and their families uphold and operate within this framework, the entrenched patriarchy operates such that women themselves measure and express their freedom of choice within this acceptable framework. According to many of the male informants, both young and old,

The woman cannot decide more than the man. (Male Unmarried under 35)

This decision comes from the man. (…) it is the man who will decide. (Male Married over 35)

It is the man. How he does it … he must tell her the reality that life is difficult. (Male Married under 35)
Women's acceptance of these socially bounded and constructed cultural expectations reflects the extent to which their ability to decide about their reproductive lives is constrained in WBeG. Women's acceptance of this unequal social order, and of the finality with which they accept their constrained agency, is illustrated by the following quote:

The decision comes from the man. Our relatives see that birth allows inheritance, and if you do not want to give birth, men do not agree. They should be the ones to take the decision because he is the person in charge. He is like the president of the house or the chief of the house. He is the one to see if his wife should give birth every year or after how many months, whether it will affect her health or affects upbringing of children or the way they live at home. (Female Married over 35)

A young woman pointed out,

If it is the woman who says that she wants to stop, they [men and society] take it in a different way. (Female Married under 35)

**Subverting the hegemony, covertly and overtly**

This constrained agency, however, is not going unchallenged; both men and women, young and old, are questioning the appropriateness and the continued feasibility, particularly economic feasibility, of the current social order. The return of peace presents opportunities; unlike before, people now see opportunities beyond just subsistence agriculture and survival. Earlier, children were seen as extra hands to till the land, and the responsibility of the parents was to provide food and shelter. Young men and women recognize these changing economic realities; they appreciate the responsibility and importance of investing in children's education; and also, that one should have only as many children as one can afford to provide good education for.

Schools are expensive, and it is good to have sex in such a way that she does not get pregnant. (Male Married under 35)

Some young men are also calling for the need for a partnership approach to deciding about family and family planning,

This family planning depends on two sides. You, the man, and the woman: this is an agreement between you, of course. (FGD Male under 35)

As discussed above, women are covertly defying this unequal social order. As the quotes below illustrate, some women are also doing this overtly, taking matters into their own hands, often
to the chagrin of men and other women, and demanding a say on issues affecting their lives. A young woman added,

You tell him [the husband], but if it is a husband that will cause problems, you don't tell him. Some men will not accept it. They don't want their wives taking contraception. … Yes, [then] you go along [secretly] and inject or take the pills. (Female Unmarried under 35)

All three traditional leaders interviewed were strongly of the view that the man should and does decide on all matters related to reproduction in the household. However, as the quote below indicates, the challenge mounted by some women to this domination by covertly and overtly taking charge of their reproductive lives is triggering a rethink among the Fertit elders and shaping a new normality:

Couples are supposed to agree together on when to produce children, but in many cases, women will say they have been told in health facilities that it is not yet time for a child. This is what is frustrating many men in families. (Traditional Leader)

This is also along the lines of what some health facility personnel and reproductive health service managers indicated: that they have recently noticed a change in the way women and couples approach the matter — perhaps, as indicated earlier, a change that is driven by the new economic realities,

It is only this year that I see women starting to say they do not want to give birth. But before this was not there; they had the appetite for childbirth. Now because life has become very difficult … this is when I saw women start to come and ask for the injection and pills. (Health Personnel)

**DISCUSSION**

Consistent with the theory of planned behaviour (Ajzen 1991, Ajzen 2002)), we found that a positive attitude and positive outcome expectations about spacing of pregnancies alone are not enough to shape decisions and behaviour; the prevalent social norms and one’s beliefs about one’s capacity to act also operate concomitantly to affect decisions and actions. The findings above show, and we discuss further in this section, how social norms shape the agency and actions of individuals, and how at the same time, broader changes in society, the social interactions between agents and their agency also shape the social norms, both maintaining and reproducing or transforming them.
The multifaceted influence of social norms on procreation decisions

Findings clearly show that while both men and women desire to have many children, they have a good knowledge of the importance and benefits of spacing pregnancies and of using modern contraceptive methods to do so. This knowledge and positive attitude towards spacing are, however, failing to translate into decisions to use contraceptives among the Fertit in WBeG. Two overlapping explanations emerge from our findings. On the one hand, social norms around pregnancy and childbearing and the entrenched patriarchal privileges intersect to concentrate and maintain decision-making powers in the domestic, economic and public realms in men’s hands, and constrain Fertit women’s agency in the reproductive realm. On the other hand, our findings also recognize that men’s agency in the reproductive realm is perhaps similarly constrained by these social norms and by the very hegemonic patriarchy that privileges men. These findings are consistent with the evidence that use of contraceptives and other SRH services is not merely a matter of knowledge and rational choice but is mediated by social norms and power relations based on gender and ethnicity (Lockwood 1995, Price 2002). They are also consistent with the large body of anthropological and sociological literature supporting the view that couples’ reproductive decisions are negotiated within gender-based power relations and within the context of local social norms and health systems (Dixon-Mueller 1993, MOH 2011, MOH 2012, Mugo 2015, WHO 2015). In line with our findings, and the hegemonic patriarchal social situation notwithstanding, many caution against a universally tyrannical representation of men’s roles in the reproductive realm, arguing that such a representation is both inaccurate and unhelpful (Connell 1995). While the findings above indicate that patriarchy has been reinforced by the violent and fragile environment of South Sudan, they also show how it is being questioned and challenged, both by women and men.

Competing social norms: an opportunity to help define a new normality

For Fertit men and women, young and old, in urban and rural settings alike, having children and expanding one’s family is an important social expectation, and people desire to have children (Page & Lesthaeghe 1981). Similar to other patrilineal and patrilocal societies in sub-Saharan Africa, marriage is a key social institution, and its primary function is ‘childbearing’, with women seen as a means of reproduction (Caldwell 1976, Caldwell & Caldwell 1987). These social norms around reproduction remain strong and entrenched among the Fertit people of WBeG, South Sudan. However, the nature of social norms is such that conformity is conditional: people would stop conforming to a norm if there were doubts or disagreements about what the norm seeks to enforce or if it cannot be enforced. Evidence shows that no matter how permanent and rigid norms might appear, in any society, competing norms are constantly at odds with each other, and norms are constantly evolving, being negotiated and being replaced by other collective beliefs about which behaviours are appropriate in society in the evolving context (Munshi & Mayaux 2006, Hammel 1990). Our findings show that Fertit men and women are challenging patriarchal social expectations, questioning, testing and transgressing the boundaries set by existing social norms and in the process opening windows of opportunity for redefining
normality in WBeG society. In addition, in both urban and rural areas, the descriptive social norm of having as many children as possible is under competitive pressure from two other social norms: the injunctive norm on spacing pregnancies, and the injunctive norm that one must take good care of children. Unlike before, when providing food and shelter was what primarily entailed providing care, nowadays, good care is understood to involve providing good education to one’s children. People also increasingly recognize that they can bear the responsibility and the cost of providing good education to only a few, and not many, children.

The post-conflict period and opportunities for renegotiating the social compact
Lianos (2012) has explored the social processes of conflict, post conflict and emergence of peace as etiologies of macro- and micro-level social change. Lianos (2012) argues that individuals, groups and other actors adjust their strategies to make the most of the new situation, thus participating in enhancing the legitimacy of the emerging new conditions. Conflict, post conflict and peace constitute social change, and social actors develop strategies to navigate it and benefit from it. This change, catalyzed by the disruption of the traditional social order as a result of the civil war, the chronic insecurity, fragility and the internal displacement, paradoxically offers women and men opportunities and resources to subvert entrenched norms and hegemonies. To some extent, the findings of this study indicate that the new political and economic realities of the post-conflict setting, and the return to peace, might be catalysing the norm change processes in South Sudan. The return to peace, and South Sudanese society’s transitions from a militaristic male-dominated society to a society now focused on nation building and with aspirations of progress, with improving access to knowledge and services, is also opening up opportunities for women and creating spaces for the renegotiation and reconfiguration of socio-political relations; and in the process also emboldening men and women to challenge the hegemonic order.

Navigating change: enabling women to exercise agency
Many Fertit, including men, do not support the status quo. However, some men, in both urban and rural areas, are wary of their women clandestinely using contraceptives. If the impression that health services are encouraging this becomes commonplace, the SRH programme in WBeG state may become entangled in the complex gender and power dynamics within society — to the detriment of women. While recognizing that social institutions such as the health services are gendered spaces, which reflect and reproduce gender inequalities in society, we argue that the WBeG SRH programme must take explicit and immediate action to prevent such an impression from emerging among the menfolk and society at large. SRH services should take care to ensure that women’s agency is not undermined in such a process, and instead work towards creating safe spaces for women to exercise their agency. There seems to be some openness to joint decision-making on reproductive matters; this is a window of opportunity to promote both gender equality and reproductive health. An explicit gender-transformative approach (Mukhopadhyay et al 2006; Mukhopadhyay 2004) that includes interventions which promote dialogue among couples, family members and society at large, and which builds on
social norms around the importance of women to be able to get ‘rest between pregnancies’, could be a feasible and effective way forward. Such an approach could also apply to other settings in South Sudan where the situation is similar to WBeG.

LIMITATIONS

The study has some limitations. Based on the conceptual framework, we expected generational hierarchies and some significant others to be important influences on decisions on sex, sexuality and reproduction. We did not find any explicit evidence of this. While men and women did refer to elders as shaping their decisions, we did not find anyone being particularly influential (e.g., mother-in-law, father, aunt). It is possible that indeed within the Fertit society, many people shape and influence decisions on these matters, and not just a few significant others; it is also possible that our data collection somehow fell short and that we have failed to identify these influences sufficiently.

The topics of sex, sexuality, reproduction and decision-making on these matters are sensitive subjects. There is a risk that people hesitate to talk openly or that they only give socially desirable answers. These constraints were anticipated, and steps were taken to loosen them. Preparatory trips were made to familiarize the study team with the WBeG context and the study sites. Much effort was put into identifying research collaborators, one male and one female, who not only spoke the local language and had experience of qualitative research but were also Fertit themselves. Preliminary visits were made to the study sites before the actual data collection, to meet the villagers and the elders, explain the nature of the study and effectively seek the village’s consent; these visits were village gatherings and, essentially, elaborate confidence-building exercises. As regards the risk of socially desirable answers, the researchers who conducted the interviews with community members know the Fertit culture well and were aware of such a risk. Furthermore, during daily debriefing sessions we involved a local resource person who is knowledgeable about Fertit society, its traditions and its social norms generally, and on matters related to SRH, to make better sense of research participants’ accounts; her involvement served as both a quality check and also an additional level of insight. Finally, the overwhelming interest and the frank interaction we encountered during data collection and given that the Fertit are not shy about talking about sex and sexuality, makes us confident of the validity of the study findings.

CONCLUSIONS

While the social norm which expects people to have as many children as possible remains well established among the Fertit community of the state of WBeG in South Sudan, it is under competitive pressure from other existing norms which make spacing of pregnancies socially desirable, and from emerging norms on what entails taking good care of one’s children. The latter is changing: the focus is moving from looking at children as labour, to investing in them and providing them with a good education. People increasingly recognize that they should only have as many children as they can afford to educate well. The long war has weakened or disrupted
the existing social norms in South Sudan. The return of peace and stability and the emergence of a new economic order are creating opportunities for Fertit men and women to challenge and reconfigure social norms on childbearing and family planning. The public health programmes in WBeG should work with and make use of existing and emerging social norms on spacing and caring for children in their health promotion activities. Instead of focusing directly or solely on reducing family size, campaigns should focus on promoting a family ideal in which children become the object of parental investment.

We argue that the conditions are right in WBeG and in South Sudan to trigger social change on matters related to SRH, and that the post-conflict environment of South Sudan and its people’s aspirations for freedom and a better life offer an opportunity to intervene to change social norms, including but not limited to those affecting reproductive health, for the better; this opportunity should be leveraged to achieve sustainable change.

DECLARATIONS

Ethics and consent to participate statement
The study was approved by the Independent Ethics Committees of KIT Royal Tropical Institute, Amsterdam, The Netherlands, in a letter dated 12 June 2014. The study was also approved by the Ethics Committee of the national Ministry of Health of the Government of South Sudan, in a letter dated 2 October 2014.

Consent to publish statements
The study participants have consented to the publication of their anonymized quotations.

Competing interest statement
All authors declare that they have no competing interests.

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Contributions
SK and MK conceptualized the study, developed the research proposal and obtained the grant and ethical approval. SK, MK, AM and MR collected the data. SK, MK and MR coded the data. SK drafted the manuscript. MK, AM, MR, MD and JB reviewed the draft manuscript and gave critical inputs to finalize the manuscript. All authors read and approved the final manuscript.

Availability of data and materials statement
The data in the form of verbatim transcripts will not be shared publicly because study participants have not given consent for this; they have consented to the use of the data to draw inferences.
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FINDINGS:
GENDER RELATIONS AND WOMEN’S REPRODUCTIVE HEALTH IN SOUTH SUDAN
ABSTRACT

Background
In South Sudan, women disproportionately bear the burden of morbidity and mortality related to sexual and reproductive health, with a Maternal Mortality Ratio of 789 deaths per 100,000 live births.

Methods
A qualitative study was conducted to analyse how gendered social relations among the Fertit people affect women’s ability to exercise control over their reproductive lives, and thereby their sexual and reproductive health. Transcripts of five focus group discussions and 44 semi-structured interviews conducted with purposefully selected community members and health personnel were analysed using Connell’s relational theory of gender.

Results
Women across all age groups report that they have little choice but to meet the childbearing demands of husbands and their families. Women, both young and old, and also elders, are frustrated about how men and society are letting them down, and how they are left to bear the reproductive burden. The poverty and chronic insecurity in South Sudan mean that many men have few sources of pride and achievement; conformity and complicity with the hegemonic practices accord both security and a sense of belonging and privilege to men, often at the expense of women’s reproductive health.

Conclusions
Inequalities in the domestic, social and economic spheres intersect to create social situations wherein Fertit women’s agency in the reproductive realm is constrained. In South Sudan, as long as economic and social opportunities for women remain restricted, and as long as insecurity and uncertainty remain, many women will have little choice but to resort to having many children to safeguard their fragile present and future. Unless structural measures are taken to address these inequalities, there is a risk of both a widening of existing health inequalities and the emergence of new inequalities.

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INTRODUCTION

Globally, women bear a disproportionate burden of morbidity and mortality related to sexual and reproductive health (SRH). De Francisco et al. (2007) argue that individuals’ SRH is shaped by the nature of intimate and family relations set within kinship structures, community institutions and relations. They add that how women experience their sexual and reproductive situation and health is embedded within a variety of gendered social relations — relations with their intimate partners, immediate family, community and, ultimately, broader society. Gender and health researchers have argued for studies to investigate the complex interaction between gender and other structures of social inequalities to understand health situations (Cottingham & Mynti 2002, Collumbien 2012). Others have pointed out that the complex nature of these interactions seems to hinder the scholarship on this subject and have urged researchers to take on this challenge (Cottingham & Mynti 2002, Ohman 2015); this paper attempts to do this in the context of the SRH of women in South Sudan.

South Sudan became an independent country in July 2011. The long war preceding independence has destroyed much of the public systems such as education, health care and infrastructure. The continued sporadic episodes of violence and chronic insecurity in many parts of the country have also disrupted the social fabric. According to the Human Development Report of 2015, South Sudan is ranked 169 out of 188 countries and territories for human development (UNDP 2015). Economically, according to the World Bank, while South Sudan has much potential, there is great inequality and widespread poverty, with 51% of the population living below the poverty line (World Bank 2015). Almost 72% of the population is under the age of 30 years; most of them are unemployed, unskilled, rural and female (World Bank 2015). Illiteracy is widespread: around 84% of all women are illiterate. Over half (57%) of all households in South Sudan are female headed (Shimeles 2012). The health system is weak, with severe shortages of health workers and poorly functioning health facilities (MOH 2012, Mugo 2015). South Sudan has a maternal mortality ratio (MMR) of 789 deaths per 100,000 live births (WHO 2015), a contraceptive prevalence rate (CPR) of just 4.7%, and a teenage pregnancy rate of 34.5 (MOH 2011, SSCCEC 2010). These indicators highlight the gravity of the SRH situation in South Sudan; while reliable data disaggregated by state and ethnic group are not available, it is reasonable to assume that the SRH situation is similar throughout the country and across all ethnic groups. South Sudan is home to more than 50 ethnic groups. While at the national level, the Dinka and the Nuer people constitute the biggest ethnic groups, in some states, other ethnic groups tend to predominate. For instance, in the state of Western Bahr el Ghazal (WBeG) the main ethnic group is the Fertit, a moniker used to refer to a loose conglomeration of more than 23 non-Dinka, non-Arab, non-Fur and non-Luo people (Personal Accounts) who freely intermarry. Unlike the Dinka and the Nuer people, who are pastoralists, the Fertit people are predominantly agriculturists involved in subsistence farming.

This paper presents an analysis of how gendered social relations among the Fertit people of the Western Bahr el Ghazal (WBeG) state of South Sudan interact and intersect to affect Fertit women’s ability to exercise control over their reproductive choices and decisions, and
thereby their SRH. Such an analysis which exposes how gendered social relations and practices in the domestic, local social and economic spheres contribute to shape Fertit women’s sexual and reproductive agency and health can inform the development of locally appropriate public policy and public health responses. This insight can also be potentially useful for other parts of South Sudan with a similar social context.

**METHODOLOGY**

Data are drawn from a two-year study exploring SRH decision-making and actions, conducted within the context of a larger SRH project implemented in South Sudan from 2013 to 2016. The SRH project aims to improve reproductive health outcomes in three states by supporting the state ministries of health and their development partners to implement the National Sexual & Reproductive Health Strategic Plan 2013–2016. Project activities are geared towards achieving three complementary objectives: improving the availability, accessibility and use of quality SRH services; strengthening capacities at all levels of the ministries to deliver quality SRH services; and generating knowledge for locally appropriate and effective approaches to improve SRH. As part of the latter, a qualitative study was conducted in Wau county to gain insight into various factors shaping people’s SRH choices, decisions and actions. Data were collected through focus group discussions (FGDs) and semi-structured interviews (SSIs) with a variety of purposefully selected informants, as detailed in Table 5.1.

Topic guides for FGDs and SSIs were developed using de Francisco et al.’s (2007) framework of ‘Circles of Influence Affecting Sexual and Reproductive Decisions’. According to the framework, men’s and women’s SRH is shaped by overlapping spheres of influence within the family, community and broader society. Individuals’ SRH is affected by the nature of intimate and family relations, including gender relations set within kinship structures, community institutions and other social relations, which are, in turn, nested in broader social institutions, power structures and ideologies. According to the framework, within these overlapping spheres of influence, individuals and social groups occupy positions of relative advantage or disadvantage with respect to their access to information and other resources; this shapes their capacity to make decisions and has important implications for their own and others’ SRH. The framework allowed the topic guides to cover a wide range of issues affecting choices, decisions and actions related to SRH, at household, community and the broader societal relations level. The topic guides for health and other workers included questions along the same lines, but with a view to exploring their perspectives on the situation. The FGD and SSI topic guides for community members were prepared in English and translated into Wau Arabic (by investigators MR and AM). The topic guides were defined further through consultations with stakeholders, and after pre-testing in the study sites, and were also adapted iteratively as the study progressed. The FGDs and SSIs with community members were conducted in Wau Arabic; interviews with health and other workers were conducted in English.

Connell’s (2009, 2012, 2013) relational theory of gender is used to analyse and explain how gendered social relations shape Fertit women’s agency in the reproductive realm, and thereby
their SRH. The theory of gender relations understands gender as simultaneously involving “economic relations, power relations, affective relations and symbolic relations …” (Connell 2009); the enduring patterns of these social relations being what social theory calls ‘structures’ (p 73). Connell (Connell & Pearce 2013) argues that an analysis of how social relations shape a particular social phenomenon or social situation should do so through an examination of the interplay between these structures — i.e. the ways they interact and shape each other and produce social situations. Connell’s relational theory of gender was chosen because it steers clear of assumptions of social categories, hierarchies and individual-centeredness; instead, by focusing on social relations and their social construction as antecedents of gendering, Connell’s framework allows one to approach any social context openly. Further, Connell’s framework does not assume social relations to be ahistorical; as Oyewumi (p 1) (2011) recommends, it allows one to “ask questions about the meaning of gender and how to apprehend it in particular times and places”. Many African gender theorists acknowledge Connell’s work as an exception to the often Western-centric and universalist theoretical perspectives on gender (Oyewumi 1998, Morrel 2016).

Study sites
The study was conducted in Wau county in the Western Bahr el Ghazal state of South Sudan. Two locations were selected based on homogeneity of the residents (all Fertit). The two locations represented two different settings: one a rural area with a tight-knit community less exposed to non-Fertit cultural influences, and the other the town of Wau, with a community with greater interaction with other communities and possibly less tightly knit. The a priori assumption behind choosing these two locations was that perhaps within the same social group (the Fertit), depending on the setting, gender relations and the enforceability of social norms might be different, and that this might have different consequences for women’s SRH.

Sampling, recruitment of study participants and data collection
Community members were purposefully selected with the help of village elders, community health workers from a local non-governmental organization (NGO) and the county health department; they were selected based on their potential to provide rich insight into the study subject. The study was explained first to the village elders, who then allowed us to talk to people in their community. This due process ensured unrestricted access to the community. The actual selection of study participants was done by the research team.

Among community members, only those aged 18 years and above were included in this study; a separate, but linked study has been conducted among adolescents. We purposefully categorized participants into those aged 18–35 years and those over 35 years. The assumption was that the two age groups might experience gender relations and their SRH-related consequences differently. Data collection began with FGDs among community members, which was followed by SSIs to obtain more in-depth understanding. For FGDs with community members, participants were homogenous in terms of ethnicity, age and marital status, while diversity was sought in terms
of social and economic status (based on inputs from elders related to social identity, ownership of assets such as bicycles, level of education). However, given the widespread poverty in WBeG, most study participants can be considered poor. Those involved in FGDs were not involved again in the SSIs. All FGDs and SSIs with community members were conducted in the local language, Wau Arabic.

Key informants were also purposefully selected based on their active SRH-related role within the study community and the local health system; they were identified through the initial stakeholder consultations. As elaborated in Table 5.1, key informants included health facility personnel from the local health centres (many of whom were from the Fertit community), traditional leaders, traditional birth attendants, state and county-level SRH service managers, and NGO representatives. Data were collected from October 2014 to April 2015 by research team members who hailed from the study area, were fluent in the local language (Wau Arabic) and had experience with conducting qualitative research. FGDs and SSIs with some health workers, managers and NGO representatives were done in English, as some of them hailed from other parts of the country and did not speak Wau Arabic (English is the official language of South Sudan). Data were collected until theoretical saturation was reached and no new insight

Table 5.1. Overview of study participants and data collection

<table>
<thead>
<tr>
<th>Method</th>
<th>Profiles of study participants</th>
<th>Number of activities (number of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Community members: Female 18–35 years (not in union*)</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Community members: Female 18–35 years (in union)</td>
<td>1 (8)</td>
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<tr>
<td></td>
<td>Community members: Male &gt;35 years</td>
<td>1 (8)</td>
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<tr>
<td></td>
<td>Community members: Male 18–35 years</td>
<td>1 (8)</td>
</tr>
<tr>
<td></td>
<td>Health workers</td>
<td>1 (6)</td>
</tr>
<tr>
<td>SSI with community members</td>
<td>Community member: Female 18–35 years (not in union)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Community member: Female 18–35 years (in union)</td>
<td>6</td>
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<td></td>
<td>Community member: Male 18–35 years</td>
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<td></td>
<td>Community member: Female &gt;35 years</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community member: Male &gt;35 years</td>
<td>4</td>
</tr>
<tr>
<td>SSI with key Informants</td>
<td>Traditional birth attendants</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Traditional leaders</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Health facility personnel</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>State SRH managers</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>NGO representatives</td>
<td>3</td>
</tr>
</tbody>
</table>

* Participants were either in union or not in union at the time of the study; we articulate relationship status this way because in WBeG one would publicly state one's status as married only if the relationship was formalized either in a traditional ceremony or in the church. For the sake of convenience, we use the terms married and unmarried in the article.
emerged; this was possible to assess, as at the end of each day of data collection, the research team debriefed and discussed the emerging findings. SSIs and FGDs were digitally recorded, translated from Wau Arabic into English (where applicable) and transcribed verbatim. The translations were independently checked by one of the co-authors (MR) to ensure that the translations were accurate. In total, 5 FGDs (with 38 participants) and 44 SSIs were conducted.

**Data analysis**

A thematic content analysis was conducted using Connell’s relational theory of gender. Transcripts were analysed using NVivo 10 software; this was done in parallel by three researchers (SK, MK, MR). Emerging themes were identified through a process of discussion and argumentation within the research team. Analysis was refined through follow-up interviews with two study participants in each study site (n=4) — one Sultan (a traditional leader among the Fertit, and in South Sudan at large) and one local resource person — and through a workshop involving community health workers, health facility personnel and SRH service managers.

**RESULTS**

Four key themes emerged. The first theme articulates the high symbolic value attached to childbearing and paternity in Fertit society; the antecedents of the high symbolic value as discussed by study participants are presented. The second theme discusses the status of women in Fertit society, the power relations in the domestic and family spheres generally, and in light of the symbolic value attached to childbearing and examines the effects of these relational arrangements on Fertit women’s reproductive agency. The third theme builds on these two themes to highlight how broader societal and political circumstances have undermined the social compact among the Fertit, and how this amplifies the unequal gender order, further undermining women’s ability to exercise their reproductive agency, and thereby their reproductive health. The fourth theme presents evidence of how social and gender relations are constantly in flux and are being actively constructed (Connell 2009) by Fertit women in relation to others at the individual and the societal level. It shows how Fertit women are leveraging opportunities presented to them by the particular setting they are in at this time, to influence the gender order — although probably in a very limited way.

**“Symbolic value attached to fertility, childbearing and paternity”**

Among the Fertit, as the following quotes show, fertility and childbearing are seen as markers of respectability and responsibility. Having many children — expanding one’s family and spreading the family name — is a key aspect of manhood.

A good man in the community is responsible. When he is a responsible person in the community, he is well respected and has his children. When a man does not have children, in the community he is seen as not responsible. [B--SSI Female <35 – Unmarried--1]
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If the boy becomes a man he needs to extend his family by getting married and having children. In this way the family expands, and they become well known to the people. [A--SSI Male <35--3]

Further, among the Fertit, children are seen as a means of carrying on one's family name; those men who do not father many children are seen as wasting their lives. Symbolically, children are also seen as a means of replacing lost (dead) family members; in fact, children are often designated as replacing specific lost relatives. In the last three decades, given the war and widespread human losses, this social practice has become a powerful force to entrench the symbolic value attached to childbearing; the result being the furtherance of the masculine hegemony, often at the expense of women's agency in the reproductive realm.

If a man stays without having children we think that he may die and leave no name behind. Whatever he owns will be a waste. [B--SSI Male <35--1]

Participant: They think of their family members who died, and they want to have children so that their family can expand, and they become proud in society as a big family. Interviewer: So men want children to carry their names? Participant: Yes, just for the name, but they cannot handle raising children. [A--SSI Female <35 – Unmarried--3].

Fertit women are expected to give birth to as many children as the man and his family members wish, since it allows inheritance and the continuation of the man's family name; this is an entrenched social norm. Consistent with the quote below, study participants across age, sex, marital status and geography note that a woman is meant to bear children for her husband's family, and that women do not really have a say in this matter.

Our relatives see that birth allows inheritance and if you do not want to give birth, men do not agree. They (husband and his relatives) don't agree when women decide they do not want to have children. [A -- SSI Female>35--3]

“Unequal status and power relations between the sexes”

The Fertit, like the other South Sudanese ethnic groups, are patriarchal; men have the power to decide on all aspects of the family and in society at large, and women's position is subordinate to men (Scott 2013, Scott 2013a, Bior 2013, Edwards 2014). The Fertit consider the notion of being respectable, and worthy, of great importance; boys and men count, while women do not. This was a cross-cutting theme across all participants; for instance, in an FGD with young women, there was consensus when one of the participants pointed this out; probing by the facilitator
led to a discussion wherein it emerged, as the following quote illustrates, that this was indeed a given among the Fertit.

A boy is respected because he is a boy. But if you are a girl, you are just a girl. You are not respected. [B-- FGD Female<35]

The following sections will illustrate how this structurally lower status accorded to women and girls in Fertit society intersects with and also shapes other structural forces and prevents women from exercising their agency in many social realms, particularly in the reproductive realm. In Fertit society, the decision-making power on matters related to sex and reproduction rests with the man and his family.

The man is the man, and this is his responsibility ... so the decision (on matters related to sex and reproduction) should come from the man, [A--SSI Traditional Leader 2]

A key feature of Fertit society is that the family is a consanguinally based unit built around a core of brothers and sisters (blood relations). The wife is not seen as part of the family, but as an outsider, whose role is to bear children for the man's family. The following interaction in an FGD among young women shows how, in Fertit society, the woman's raison d'être is her ability to produce children for the man, and for his family.

Participant 1: If you are married and already living with your husband and do not have a child, the husband can leave you and tell you to go back to your family.
Participant 2: His relatives will come and argue that why you are not getting pregnant and sometimes that you are barren. The man's relatives will complain why is this woman brought and eating our food for free if she is not going to deliver children.
Participant 1: The relatives will tell the husband to leave you and go and get another woman who can have children. Participant 3: Or the (man's) relatives themselves will go and get a wife for their son. [B--FGD Female<35]

Women who wish to differ and make their own reproductive choices are subject to serious social pressures, particularly from the husband's family. Women are often at risk of being abandoned by their husbands; and, given that economic opportunities are so few in South Sudan, particularly for women, they are left with no choice but to submit to the demands of the husband and his

1 Prefix 'A' refers to participants from study site around Wau town; 'B' refers to participants from the rural location in Wau county. During data collection we realized that the distinction was immaterial, as the town is merely a larger village.
family. As the following quotes from two young women highlight, these unequal power relations are reflected within intimate partnerships too. Many women see themselves as beholden to the man who brought them into his house. Not only do women need to consider it their duty to listen to their husband, not refusing to have sex is seen as essential to being able to keep one’s husband, and as key to preventing him from going to other women. This surrender of agency is thus driven by a confluence of the social position of women in society, the fear of the man bringing home sexually transmitted infections, and also, given the harsh economic situation of South Sudan, the fear of abandonment.

A woman’s responsibility is to listen to her husband, do the house work and look after your children, and you don’t roam randomly outside. You listen to the person who brought you at home. [A--SSI Female<35 –Married--1]

The man insists on sex, and if the woman refuses he will go look for another woman. So, if you want to keep your husband, you need to have sex with him whenever he wants (…) So women try to please their husbands; that is why they become pregnant without planning. [B--SSI Female<35--Unmarried--1]

In WBeG, and across South Sudan, women outnumber men, are poorer than men and are less educated than men. Economic opportunities are few for women, and many women are dependent on men (World Bank 2015, SSCCEC 2010). Our findings show that many women are left with no choice but to resort to competing with each other to keep their men by using their capacity to bear children for him and his family. The following interaction in an FGD among young married women highlights the insecurities they experience; it shows how social structural forces intersect to compromise their agency in the reproductive realm.

Participant 1: The woman will say it is enough and the man will say he wants more and there will be a lot of pulling between them here. Participant 2: If you don’t want …. You go to your home. Interviewer: What happens after she returns to her family? …. The husband will get another wife? Participant 1: The husband will get another wife … Again, after you. Participant 2: It won’t take long … he will bring another woman. [B--FGD Female<35]

The following example, given by one of the health care providers, is a particularly incisive reflection of the complicated situation many Fertit women are in,

Women say that they have to give birth so that their husbands don’t leave them. You find men having two wives, and each wife thinks that childbirth will make the man not go away. Once a woman came here and her husband is in Khartoum and she has 10 children and she has a tubal ligation [a non-reversible method to prevent
pregnancy involving surgery on fallopian tubes]. I think she has fibroids [fibroids are benign masses in the uterus], but she told me that she feels she is pregnant and she wants to give birth because she has a new husband and she needs to give birth for him.  
[A--SSI Health Facility Personnel--2]

**Breakdown of traditional social contracts as amplifiers of gender inequalities**

There is some evidence that civil wars and chronic conflicts may increase the risk of death and disability through the breakdown of social norms and practices which maintain social order, and that women and children bear most of the long-term burden of the consequences of this breakdown (Ghobarah 2003, 2004). Our findings also reveal that the long war and ongoing insecurity have undermined the traditional checks and balances in Fertit society. In the traditional Fertit family structure the children belong to the man and to his family, and the man and his family are expected to take responsibility for the wife and her children. Mechanisms, both formal and traditional, for maintaining and enforcing this social contract, wherein men take responsibility for their family, have been weakened, to the detriment of Fertit women’s agency generally, and in the reproductive realm in particular.

A recurring theme throughout the study, both among old and young, was of men increasingly abrogating their responsibilities towards their wives and children. As the following quote from an FGD involving older women illustrates, in the current context, Fertit society is falling short by sanctioning traditionally unacceptable behaviours — causing much hardship to women.

Giving birth during our time is not like giving birth now. During our time when a woman gives birth you work on the farm … your husband also supports you, he brings everything. But childbirth nowadays … the boys never care about their wives, when she is pregnant whether she is eating or not or whatever she is doing is not his problem … This brings a lot of hardship to women.  
[A -- FGD Female> 35 - Married]

This loss of social control was poignantly articulated by an elderly NGO worker who hailed from the Fertit community; she said,

It is true our time was not like this. Because when we were young girls of course you will love a boy, but that boy is afraid to touch you. You will write letters … I love you … you will sew handkerchiefs for your boyfriend, but he will never touch you … because he is afraid.  
[SSI NGO Worker]

They [boys] go get girls pregnant and … there is nothing girls can do … they drop out of school and suffer raising their children, even [having to] go and sell goods in the market.  
[A--SSI Female<35--Unmarried-3]

As the above quote from a young, unmarried woman shows, some women feel helpless; they feel let down by society, being left to bear the burden of pregnancy, childbirth and childrearing.
Health workers, themselves Fertit women, born, raised and living in the area for a long time, also recognized this breakdown of social control in their society. They acknowledged that there was widespread frustration among women about men's behaviours, and about society's failure to exercise social control. They highlighted various instances of men's abandonment of women, adding that this was a major social problem in WBeG, and also beyond.

I will tell you the truth, between our time and now there is a big difference. During our time when a boy reaches puberty and is still living with his parents he cannot go on his own and choose a girl it has to be through your family, your father or your mother. But now young boys who have not yet become responsible, date girls, rape them and impregnate them and later on refuse to have them as their wives. [B--SSI Health Facility Personnel--2]

In Fertit society, not only do the children belong to the man's family and are his responsibility; the woman is an outsider and does not belong to the family. A Fertit woman's position in the family structure is in many ways contingent on the effectiveness of social control and on men acting responsibly. During fieldwork, women across age groups pointed out that not only were the traditional marriage practices gone, the social expectations and responsibilities that accompanied the traditional way of organizing a family were also no longer enforceable in the current context, to women's great disadvantage.

At this time there is no marriage you just cohabit and if you don't want him any more then there is nothing; you just leave. If he removes your belongings, it's ok … if not you take them yourself and leave. This is what is happening here … not like before. [A--SSI Female<35--Unmarried--2]

Oyewumi (2002), citing Sudarkasa (1996), has argued that gender relations in African societies should be examined within the frame of a “consanguinally-based family system built around a core of brothers and sisters-blood relations”, wherein the spouses are considered outsiders and therefore not part of the family, instead of the Western frame of the conjugal based family built around a couple. She argues that doing so allows one to understand the status of the woman in relation not merely to her spouse but to his family, which consists of him and his siblings. Consistent with Oyewumi’s point, our findings show that Fertit women see this abrogation of responsibilities as not just their husband's failure, but also as a failure of his family to keep their part of the bargain, and as a failure of the society to enforce it.

Influencing the gender order
A key theme we recognized throughout the study was that this abrogation of men's responsibility and the failure of Fertit society to check it, is catalysing a situation wherein women are taking responsibility and decisions into their own hands. One might argue, as the following quotes
from younger female participants indicate, that they are in the process of proudly pushing back and challenging the unequal gender order in Fertit society — albeit in a small way.

Women do anything, any kind of business that will bring income so that children can have food ... women will do it. For example, in my house I bake bread and brew alcohol and I eat with my children if our supply finishes I go and buy more and we can have something on the table. I save my money to support my children in school. This time I registered my children in schools. ... It is not their father. [A-- SSI Female<35 Unmarried--2]

Participant: The men nowadays will make you bear a lot of children and they don't take responsibility. That is why women say go find another wife to give birth to you, me ... I am done with childbirth. [A--SSI Female<35--Unmarried--3]

All three Sultans interviewed also recognized this social situation. They were clearly disappointed with many men's conduct, particularly about men not taking their social responsibilities seriously. As the following quote by a Sultan shows, they also rued how many women were increasingly taking their lives into their own hands.

Like I have just mentioned men fail to take responsibility (…) In our community in South Sudan I now see that women are more responsible than men because when you wake up in the morning you see women going to work, to farms, to different places ... and women ... they are doing better in raising children than men. These days people are failing in life and the failure comes from men. Because when you give birth to five children you need to send them to school, treat them, and do so many things, so every morning men have to go and find ways of feeding children (and they don't) .... [A--SSI Traditional Leader--2]

Based on what we were told by some participants and based on the work of South Sudanese social scientists (Bior 2013, Edwards 2014), we expected the Sultans to be the conventional guardians of Fertit patriarchy, devoted to justifying the status quo. On the contrary, as the above quote also illustrates, they seemed to not just acknowledge these societal failures, but, based on our insight from the fieldwork, were also quite open to a situation where women run the show. The Sultan's views were echoed by many male study participants; these views perhaps signal the existence of much more fluid and flexible social relations in Fertit society than we were able to uncover in this work.

**DISCUSSION AND CONCLUSIONS**

A key feature of Fertit society is the high symbolic value it attaches to fertility and childbearing. The family is a consanguinally based unit built around a core of brothers and sisters (blood
relations), with the wife not seen as part of the family, but as an outsider whose role is to bear children for the man's family. Another key feature, which is linked to the structure of the Fertit family, is the notion that the children belong to the man and his family, and that the children's upkeep is their responsibility. This responsibility extends to the children's mother, but is tacit, and in some ways contingent on her ability to continue to bear children. These social structures serve as the context within which gendered relations are enacted in Fertit society to create social situations wherein Fertit women's agency in the reproductive realm is constrained. We discuss women's accounts of constrained agency within three broad perspectives on fertility choices and decisions around fertility in contexts like that of South Sudan, to arrive at conclusions.

We reflect on these accounts by locating them within broader discussions on the privileges of motherhood and childbearing in the socio-political context of South Sudan, by examining women's accounts of men's conduct within a broader understanding of men's imperatives to conform to the hegemonic masculine order, and, finally, by discussing how these explanations are possibly shaped by the overarching structural forces related to chronic insecurity and emerging changes in the economic order. In doing so, we also arrive at conclusions of relevance to sexual and reproductive health policy and practice in the Western Bahr el Ghazal state of South Sudan.

Green and Biddlecom (2000) have warned researchers, particularly those examining decision-making in the reproductive realm, against a simplistic problematization of men's role in women's reproductive health; they argue that "men as well as women may have financial motives for sex, because children may legitimate partners' claims to one another's resources". While this was not made explicit by study participants, we did find evidence of women pandering to the paternity claims of multiple men simultaneously, to ensure their own, and their children's financial and social protection. Without in any way condoning the unequal and unfair treatment of women, Green and Biddlecom's (2000) thesis allows one to see many Fertit men's actions as being socially constructed and a consequence of, and a means towards sustaining, actively or complicitly, the accrual of what Connell calls the "patriarchal dividend" (Connell 1993). The dividend refers to a series of material practices, which include political, cultural, economic and social advantages over women and over men who do not confirm to the dominant form of masculinity. In the context of South Sudan, given the chronic insecurity, opportunities for economic development and social achievement for men are few, and so are thus the resources to confront entrenched hegemonies. Therefore, in an environment where many men have few sources of pride and achievement, conformity and complicity with hegemonic practices accord both security and a sense of belonging and privilege — clearly a safe strategy for many men, given the current context of South Sudan.

Caldwell and Caldwell (1987) urge those studying fertility and related decision-making in sub-Saharan African societies to recognize that, unlike in Western and Oriental societies, in sub-Saharan Africa, the overarching emphasis in society remains on ancestry, descent and family lineage. The experience and understanding about the cost of fertility are fundamentally different; they contend "that high fertility does not carry economic penalties, while the foreigner's experience has been very different". Furthermore, historically, they argue, the demographic
reaction in the period following chronic conflict and insecurity involving large-scale social disruption and human loss is a rise in fertility (Caldwell 2004); this thesis has been well established over the last two decades (Schilndler & Tilman 2011, Urdal & Che 2013). This is likely to be so for South Sudan as well.

Caldwell (1978), and Caldwell & Caldwell (1987), further argues that in contexts with insecurity, poverty and uncertainty, women, by having many children, are in fact in some ways exercising their agency, however constrained it might be. There is a large body of literature that contends that children are a valuable resource for poor people, particularly poor women for whom children are a source of prestige, offer an old-age insurance policy in face of insecurity and also serve as extra hands to do much of the labour-intensive domestic and subsistence work (Caldwell 1982). Palmer (1991), building on Caldwell’s thesis, concludes that in contexts of insecurity and uncertainty, where there are few possibilities to plan for a better future, “women may retreat into their traditional role of motherhood for securing labour assistance and old age support”. Contrary to this thesis, we found that the social norms among the Fertit are such that the children are normatively seen as assets of the man and his family, and women do not generally have the social space to claim them as a resource, nor as an old-age insurance policy in the face of insecurity; in a separate paper we dwell in detail on social norms among the Fertit (Kane et al 2015). We contend that Fertit women’s narratives should be understood as being shaped by the social structures they inhabit. Fertit women are socialized to not expect and publicly stake a claim to their children as being theirs and as being their resources; instead, their statements actually reproduce the social structure by reaffirming that the children they bear are for the man and his family. This perhaps explains why, in our data, women never explicitly claimed their children as their resource, and are conspicuously silent about it. This explanation mirrors Oyewumi’s (2002) assertion that, in many African societies, the family is not built around the conjugal couple but is consanguinially based and built around a core of brothers and sisters (blood relations), with the spouses considered outsiders.

During the interviews, study participants did not refer much to insecurity and violent conflict. This could be a reflection of their acceptance of the situation as the normal state of affairs and taking it for granted, or it might reflect the relative security that WBeG has enjoyed. That said, evidence from conflict studies shows that chronic insecurity and conflict undermine women’s agency in all social realms, including the reproductive realm (Urdal & Che 2013); that it affects women’s health disproportionately (Ghobarah et al 2003, Ghobarah et al 2004); and that it does so through further entrenchment of hegemonic patriarchy. The absence of social order and rule of law in WBeG, and in South Sudan at large, the result of chronic insecurity and conflict, are key drivers of exaggeration of the inequalities in social and economic relations in Fertit society. It allows those in positions of relative power, usually men, to act with impunity at the expense of liberties, opportunities and dignity of the weak, often the women. Caldwell and Caldwell, in their seminal work in the 1980s and 1990s, observed and predicted that the new economic and social order would undermine this high-fertility system (1987). Their contention was that in the new economic order, a move away from a subsistence agriculture-based economic model to a more mixed economic model would increasingly expose the incompatibility between
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high fertility and the high costs of raising children and the ever-greater costs of education. This demographic trend is being observed in some sub-Saharan African societies, but not in others (Bongaarts & Casterline 2012, Kuate-Defo 2014); what will happen in South Sudan remains to be seen. In a separate paper we have discussed how social norms shape reproduction and family planning-related decisions among the Fertit (Kane et al 2015); we have specifically examined how norms are evolving, and why.

In conclusion, Fertit women’s reproductive choices and decisions are not totally their own, nor are they only the function of their capability to make decisions, but, in the current context and time, are shaped as much by the society in which they live. This has important implications for public health policy and practice. It is important to recognize that the Fertit people desire to have children, and that such a desire is not only rooted in the Fertit culture; it is in line with the demographic experience in other such contexts. Any policy which does not take this into account is not only likely to fail; it will not serve people’s needs and might backfire. On the one hand, the consanguinely based family structure among the Fertit is unique and has its own social logic and relationship dynamics. This social logic is, however, failing Fertit women, and they are feeling let down by society. Interventions for improving Fertit women’s SRH should necessarily address this problem. To have an impact on all these fronts, interventions need to target not just women, but also need to engage actively with the complex social situation by including men, their families and Fertit society at large.

The return of peace and the re-establishment of law and order in South Sudan will improve access to health care services and will most likely help improve Fertit women’s reproductive health. But the emergence of a non-agrarian economic model, and the expected oil-driven economic upturn, is likely to be a mixed bag for women, particularly poor women. An adult female illiteracy rate of 84%, coupled with decades of constrained agency due to war, and structurally unequal gender social and economic relations, means that women in WBeG are less likely than men to be able to benefit from the opportunities that will emerge with the return of peace. Therefore, in WBeG, and in South Sudan generally, as long as economic and social opportunities for women remain constrained, and as long as insecurity and uncertainty remain, many women will have little choice but to resort to having many children to safeguard their fragile present and future. The high fertility and poor health care services will together continue to imperil the health and lives of women in South Sudan. Unless structural policy measures are taken to address these inequalities, the disadvantaging of women, particularly poor women, may be further amplified, and there is a risk of both a widening of existing health inequalities and the emergence of new inequalities. These conclusions are consistent with the conclusions of a recent review of gender equity and SRH in Eastern and Southern Africa (MacPherson et al 2014).

DECLARATIONS

Author contributions
SK is the principal investigator. SK and MK conceptualized the study, developed the research proposal and obtained the grant and ethical/administrative approvals. SK, MK, AM and MR
collected the data. SK analysed the data and drafted this manuscript. MK, AM, MR, MD and JB reviewed the draft manuscript and gave critical inputs to SK to finalize the manuscript. All authors read and approved the final manuscript.

**Ethics and consent processes**

The study was approved by the Independent Ethics Committees of KIT Royal Tropical Institute, Amsterdam, and of the national Ministry of Health of the Government of South Sudan. Administrative approval was given by the WBeG state Ministry of Health. Informed written consent was sought from all participants; for those who could not read, the consent form was read out to them, and their consent was recorded. Confidentiality was maintained throughout, and steps were taken to anonymize the data and to minimize risk of accidental disclosure or access by unauthorized third parties. Since the broader study included questions about the local SRH services and the responsiveness of providers, steps were taken to ensure that identities of participants were not revealed to the local health workers. At the beginning of the consent process, participants were informed of their right to refuse to answer questions they might find intrusive. Furthermore, given the sensitive nature of the topic, there is a risk of opening up hitherto closed, yet painful chapters and experiences in the person’s life. To ensure support if such a situation arose, a trained counsellor was available, as were medical referral services. No such situation requiring counselling or medical referral emerged during data collection.

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FINDINGS: “YOU HAVE A CHILD WHO WILL CALL YOU ‘MAMA’” – UNDERSTANDING ADOLESCENT PREGNANCY IN SOUTH SUDAN
ABSTRACT

Background
Pregnancy amongst adolescent girls is common in many parts of the world. The dominant discourse in public health unquestioningly paints this as a problem; it does not pay sufficient attention to girls’ views.

Objectives
This paper presents a critical account of adolescent South Sudanese girl’s reasons and explanations of childbearing. It discusses their experiences and views on childbearing and attempts to explain their reproductive choices and actions, in context.

Methods
The study draws upon 24 interviews with adolescent boys, girls, and parents from Wau, South Sudan. Data was analysed using the framework analysis approach.

Results
Three interacting themes within which adolescent girls framed their views and decisions about childbearing are identified. The local society places high value on motherhood – adolescent girls’ desires to become mothers is but a reproduction of this social norm. Girls linked having a child to the possibility of making one’s ‘own home’; in the difficult and uncertain context they lived in, for many girls, having a child (and making a home) appeared one of the few means to be happy. In making the decision to bear a child, the girls navigated multiple dilemmas and trade-offs between an unpromising present and an uncertain future. Bearing a child and making one’s ‘own home’ was seen as a way to exit into the world of adults, and as a strategy towards achieving security and stability.

Conclusions
Instead of simplistically problematizing adolescent pregnancy in South Sudan, it is important to take into account the experiences and standpoints of adolescent girls, and to recognise that in choosing to become mothers, they are in many ways exercising agency despite being severely constrained by complex, insecure and unfair social circumstances. We argue that such an approach will allow the development of more appropriate, realistic and inclusive health and social policies and programs.

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BACKGROUND

South Sudan has experienced war and civil unrest for much of the last two decades. As a result, it features low on all global health and development performance indices. In terms of sexual and reproductive health (SRH), South Sudan’s challenges are particularly telling. Almost half of its population is below 20 years of age, and as UNICEF’s State of the World’s Children report of 2016 highlights, a disproportionate part of this burden is borne by adolescents, particularly by girls (UNICEF 2016). According to the national family planning policy of South Sudan ‘by the age of 19, one out of three girls is already married or in union; and the same proportion has already started childbearing’ [MOH 2012 p2]. Evidence shows that in contexts like that of South Sudan, pregnancy and childbirth carry higher risks during adolescence, with risk of mortality being almost twice as high when compared to women in their twenties; adolescent mothers also have a higher risk of non-fatal pregnancy and childbirth related complications; the risks of low birth weight, stillbirth and neonatal death are also greater among adolescent mothers (WHO 2007, Neal et al 2016, Pradhan et al 2015).

In view of these concerns, and given the evidence, the family planning policy of South Sudan explicitly seeks to ‘promote an enabling legal and social-cultural environment that ensures individuals, especially women and girls are able to claim and exercise their rights’ [MOH 2012a p4]. International organizations, the most important actors in the public health arena in South Sudan, also echo these concerns; they have regularly called for, and resourced, public policy and program responses to tackle early marriage, early childbearing, and the associated health problems in South Sudan (UNICEF 2016, Human Rights watch 2013, Jurgens 2013). Many studies and reviews have highlighted that social and economic factors are key drivers of adolescent pregnancy (Marston & King 2006, Mc Queston et al 2012, Decker et al 2017, Mmari & Blum 2009, Acharya 2010). In their comprehensive review, Mc Queston et al [2012: p45] argue that ‘to the extent that adolescent fertility is symptomatic of deeper factors, policymakers should focus on the distal rather than immediate causes of early childbearing.’ One of the key insights they arrive at is that attributing pregnancies amongst adolescents to lack of knowledge about SRH or a lack of economic resources, as many are often wont to, is simplistic, and rather that often girls’ desires to have children are rooted in social pressures to become pregnant, and that they are often shaped by a social context which either offers no incentives to delay fertility, or conversely, offers incentives to bear children (Heavey et al 2008, Davies et al 2004).

Echoing Mc Queston et al’s (2012) conclusions, through this paper we argue that public policy responses, including the reproductive health policy responses, would be more effective if the reasons of early childbearing amongst adolescent girls in South Sudan were better understood, and better taken into account. Crucially, as Heavey et al argue (2004), current sexuality education interventions tend to be grounded in the notion that adolescents are becoming pregnant by mistake and that more information about, and access to, contraceptives will lead to a reduction in pregnancy rates among adolescents (see also Davies et al, 2008). In this regard, feminist scholarship is critical to the current debate, particularly that which has highlighted the normative underpinnings of SRHR initiatives. As authors such as Mann (2013)
contend, SRH interventions geared at economically disadvantaged young women and men are often underpinned by discourses of deviance and normalization and need to be understood as sites for regulating young women’s sexuality. Building on these authors, we argue that in contexts where adolescent girls desire pregnancy, current approaches to preventing adolescent pregnancy are not only likely to continue to fail but also potentially do harm by implicitly framing adolescent mothers as deviant. More texturized understanding of adolescent girl’s motivations with regard to childbearing is crucial to developing not only more ‘effective’ but also more inclusive programs.

However, bar research by the authors mentioned above, little is known about adolescent girl’s desires to bear children, particularly in the Global South. In this paper, we seek to provide a hitherto unreported account of adolescent South Sudanese girl’s reasons and explanations of childbearing. We analyze adolescent South Sudanese girl’s views on pregnancy and the value they attach to childbearing in an effort to understand the critical drivers of pregnancy among adolescent girls. In doing so, we reflect upon the implications of this insight on sexual and reproductive health policy and practice in South Sudan. This paper presents findings from a study conducted within the context of the South Sudan Health Action and Research Project (SHARP) project in Western Bahr el Ghazal State (WBeG) of South Sudan. The project was implemented between 2012 and 2016 and was geared towards supporting the State Ministries of Health of three states (including WBeG) to improve the quality and responsiveness of the sexual and reproductive health services. Findings from research done amongst adults have been reported earlier (Kane et al 2016, Kane et al 2016a, Kane et al 2018); these papers discuss how social norms and gender relations shape women’s sexual and reproductive health in South Sudan.

METHODS
A qualitative study was conducted in one of the SHARP project sites – Wau county in Western Bahr el Ghazal State of South Sudan. Data was collected through in-depth interviews conducted with purposefully selected participants, as detailed in Table 6.1. Interview topic guides were developed based on the insights gained from earlier work conducted amongst adults (Kane et al 2016, 2016a, 2018), and included questions exploring norms and beliefs about sex, sexuality, childbearing, and on what shaped these amongst adolescents. The topic guides were defined further during the initial stakeholder consultations, pre-tested in the study site, and were also adapted iteratively as the study progressed. The topic guides were prepared in English and translated into Wau Arabic. The interviews were conducted in Wau Arabic, a language spoken by all around Wau.

Sampling, recruitment of study participants and data collection
Based on the recommendations of the scientific and ethical review group’s observations on reproductive health research involving adolescents (WHO 2017), boys and girls between 16 and 20 years of age were included as participants. Adolescents were purposefully selected according
YOU HAVE A CHILD WHO WILL CALL YOU “MAMA”

to criteria that were identified based on insights from earlier studies with adults. Included in the study were: both boys and girls; both those who were currently in union, and not currently in union; both those who were in school and not in school. Amongst girls, those with children and those without children were included. Adults who were parents of adolescents were also interviewed. Participants were recruited with the help of a local youth outreach worker and through a snowball sampling approach.

Data were collected between April 2014 and November 2015. Interviews were conducted by research team members who were fluent in the local language and had experience with conducting interview based qualitative research. Data were collected till analytical saturation was reached, and no new insights emerged; this was possible to assess, as at the end of each day of data collection, the research team debriefed and discussed the emerging findings. In total 24 interviews were conducted.

Data Analysis
Interviews were digitally recorded, translated from Wau Arabic into English, and transcribed verbatim (with assistance from two local research assistants). A framework analysis of the data was conducted as per Ritchie & Spencer (1994). Data analysis was done in parallel and iteratively by two researchers (SK, EM) who read through the transcripts, and the notes from the post data collection daily debriefing sessions, to identify key issues and themes. The indexing, charting and mapping of the transcripts was then done using NVivo 11 software. The interpretation of emergent themes was done through a process of discussion and argumentation (SK, EM); the emerging themes and explanations were written down, further discussed, and then finalized.

RESULTS
We identified three interacting themes within which adolescent girls framed their views and experiences about childbearing. The first theme relates to the various ways in which girls and the society at large, value motherhood. Linked to the first theme, the second theme relates to

<table>
<thead>
<tr>
<th>Interview Participant Profile</th>
<th>Numbers</th>
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<tbody>
<tr>
<td>Adolescents</td>
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</tr>
<tr>
<td>Female In School – With Child</td>
<td>2</td>
</tr>
<tr>
<td>Female In School – No Child</td>
<td>5</td>
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<tr>
<td>Female Not in School – With Child</td>
<td>4</td>
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<tr>
<td>Male In School – No Child</td>
<td>4</td>
</tr>
<tr>
<td>Male In School – With Child</td>
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<td>Male Not In School – With Child</td>
<td>4</td>
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<td>Parents</td>
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<td>Parent</td>
<td>3</td>
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<td>24</td>
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Table 6.1. Study participants
how having a child is a fulfilling experience for adolescent girls, particularly in combination with making one's 'own home.' For many girls, having a child (and making a home) appeared one of the few means to be happy, in the difficult and uncertain context they lived in. The notion of 'home-making' emerged as a major and multifaceted theme that variously related to the first two themes. The third theme locates girls' decisions to bear a child and to make a home as processes of navigating dilemmas where girls make very personal trade-offs between an unpromising present and an uncertain future.

**The entry into adulthood: motherhood (and fatherhood)**

Girls' accounts of the value of motherhood, including their own motherhood, and how having a child was seen amongst their peers, and by their parents, reveal that having a child seems to somehow define one's worth and establish one's claim to adulthood. Amongst the study participants, the girls who had children of their own, whether they were in school or not, seemed to take much pride in being mothers. This pride was akin to a certificate of honor, marking entry into adulthood, as mentioned in the quote below.

‘They tell us that we do not have any value because you do not have children. It is better to have a child. This way you will be considered to have two certificates, one for the school and another for motherhood. They also tell us that having your own home is the best.’ [Girl in School]

The following quote by a young mother illustrates how motherhood is also seen as signaling entry to womanhood and into the world of adults and how it somehow entitles one to have a say in the community. This notion of having a child and being responsible for the child was a common narrative among young mothers. Young women's accounts suggest that having a child was not seen as being burdened with responsibilities, but rather about being seen as someone who was capable of shouldering responsibility as an adult, and as someone able to guide her children.

Interviewer: 'What does becoming a woman mean to you?' Participant: 'It means to become a mother, and she guides her children and people in the community' [Girl in School – With Child]

This attachment of high value (amongst girls) to childbearing, was consistent with, as reported earlier in a study amongst adults, with the local social norms (Kane et al 2016, 2016a). One can argue that in saying the above, the girls was merely conforming to particular social norms, and perhaps mimicking what they saw the adults around them, value. The adult's/the parent's views were mixed; the following quotes from the mother of a girl (a girl who got pregnant while still in school) show that, even as she acknowledged that a girl's pregnancy is appreciated in the community, she wanted her daughters to focus on their education.
Interviewer: ‘How does the community look at a girl who becomes pregnant?’
Participant: ‘It is seen as a good thing especially given her young age.’ Interviewer:
‘You as a mother, what do you expect from your daughters?’ Participant: ‘I expect my
daughters to get a good education and leave all the nonsense alone’ [Parent of Girl in
School – With Child]

While to an outsider these views might appear to be contradictory, to the parents themselves,
it was only problematic if the man who had made the girl pregnant did not take responsibility
and did not provide for the girl and the baby. In the case of the parent who is quoted above, at
the time of the interview, her daughter was pregnant again, from the same man. To us it appeared
that as the man supported the girl (even if he did not marry her or take her to his house, as is
customary), the girl’s mother (and the girl’s father alike) had no problems with looking after
their daughter and their grandchild, keeping the two in their house, and helping her to finish
her schooling. This interpretation is consistent with finding from our earlier work (Kane et al
2018a), and, as the following quote shows, also with what the young men in this study said,

Interviewer: ‘What would make (the community members) happy or … make them
angry?’ Participant: ‘By God, if you beat her or impregnate and leave her. By that, her
family becomes angry, or she becomes angry too’. Interviewer: ‘OK’. Participant: ‘Then
they say that the boy has impregnated her and left her, you see how the boys … behave
[…] Yes, if you impregnate her and take her responsibility… maybe people can be
happy with you.’ [Young Father – Not in School]

All the young men in this study were sexually active, and all except two, were fathers. All
the young men, consistent with the findings from our work with adults (Kane et al 2018a),
equated fatherhood, with being and becoming a man, and being considered a ‘good man’, with
being a ‘responsible man’. Also, similar to our earlier work with adults, all participants in this
study, including all the young men, felt that a responsible man, however young he might be,
was someone who would step up and accept responsibility if he had impregnated someone -
and would provide for the mother and the child. All the young men reported that if one did
not take care of the mother and the child, it was a matter of shame. This was so much so that
many young men had fled the town because they could not (or did not want to) fulfil their
paternity responsibilities.

The value of motherhood: carrying one’s name forward
A further point that underscored the value of having a child related to the cultural notion of
having someone to carry one’s name after one dies. The girls in the study consistently talked
about how having a child ensured that their name would not be forgotten; a common reasoning
across the girls interviewed was that it was better to have a child as soon as possible, lest one was
to die prematurely – a very real risk in the context of South Sudan.
CHAPTER 6

Interviewer: ‘So they want to have children to carry their name in the future?’
Participant: ‘Yes, they see it as becoming famous. Some also say that there is premature death that can come unexpectedly, so it is better to have a child so that if I die my name will not be forgotten. When they see my child, they will say this is so and so’s child.’ [Girl in School]

This finding perhaps represents a shift of sorts, in the local social and gender norms around who has a claim to the child and whose name the child carries into the future. In the local society, the family is a consanguinal unit built around a core of brothers and sisters (blood relations); the wife is not seen as part of the family, and her role is to bear children for the man’s family, ostensibly to carry the man’s and his family’s name forward (Kane et al 2016). While in our earlier work with adults (Kane et al 2016a), women and men were very clear about who had the claim on the child (the man and his family), and whose name the child would carry into the future (the man’s), the girls in this study saw the child as very much their own and someone who would carry their name forward.

The value of motherhood: A meaningful and fulfilling experience

For girls, whether they were in school or not, having a child of one’s own, was important; it was seen as a source of fulfillment and it added a sense of meaningfulness to an uncertain present and unpredictable future.

Interviewer: ‘Why do you wish to have a child? Participant: ‘It means that you have a child who will call you ‘mama’’. Interviewer: ‘Can you explain?’ Participant: ‘It can be next to you … will listen to you, you play with it, and will be in your life always and will call you my mother and so on.’ [Girl Not in School – With child]

While on one hand young women reported experiencing pride, and a sense of fulfillment and purpose, on having children, many young mothers also consistently reported being disappointed with their lot. This tension between, on one hand the desire and need to fulfill one’s own and to some extent social expectations related to fertility, and the belief that having children was essential for attaining adult status, and on the other hand, the price one had to pay for early childbearing, specifically in terms of dropping out from school, was a dilemma all girls seemed to grapple with. This tension was clearer in young mothers’ descriptions of their lives, particularly of those who had to drop out of school as a result of becoming pregnant. The following excerpt from a young mother who had to drop out of school, reflects her disappointment, worry and despair, including but not limited to, for having to forego school.

Interviewer: ‘Ok, girls … when they have babies how do they see themselves? […] what will happen?’ Participant: ‘There are others who feel happy and others don’t.’ Interviewer: ‘Why will one not feel happy?’ Participant: ‘How am I going to think
about the future of my child and my studies, and my child's schooling, when he grows up, he wants to eat, drink, clothes … ' […] 'I feel that who will stand by my side when my child is big … then nobody would stand beside me and …' [Girl Not in School – With child]

While the young men in the study did not have much to say about how they thought the girls related to and experienced being pregnant and having children, their views on being a father, were mixed. As the excerpt from a young father shows, for some it was clearly important, but for some, not so.

Interviewer: 'Do you hear many boys hoping to have children and to be called dad or no one wants children?' Participant: 'Some love to be called dad but other don't want that. Some say if you don't have a child when you die, god is going to ask you that … he sent you to the earth and what have you done for Him.' [Young Father – Not in School]

Home making: A means to stability, self-worth and happiness

Participant: 'Those who leave school think that the most important thing is to have their own home [...] as a wife and mother' [Girl in School – No Child]

'Instead of staying at school all day and not having money for breakfast it would be better to become pregnant and stay home [...] this is what most girls are saying.' [Girl in School – No Child]

As the above quotes allude, the notion of having a 'home' was integral to young women's narratives as to what it meant to become a woman and establishing a family and life of their own. The excerpts above, from two school girls (with no children) similarly highlight the centrality of 'home-making' and all it entailed – having a child, a husband and thereby social standing as a wife and mother – in young women's lives. As another young school going woman explains when asked as to how young women in her surroundings perceived the role of a woman:

'Girls think that becoming a woman means that you will be happy in your home and you will not need anything. You will have enough money and you will have the say in the home.' [Girl – In School – With Child]

The quote highlights the view amongst girls that creating one's own home will not only offer them financial stability but also a measure of independence, voice and, ultimately, happiness
that they may not have in their current home, either parental or otherwise. A young father similarly engages with the idea of stability, as well as alluding to the pressures of ‘people’ on young women who had not yet established their own homes:

‘For an unmarried girl, she has no husband any way. […] There are people who insult her that, [saying:] ‘Aha!’ […] She is useless […] if not she should have been made stable at home by someone and have children.’ [Young Father – In School]

Home making: Balancing between peer and social pressure

The above quote (from the young father) signals that a young woman who had not no children or had not yet found someone to ‘make her stable,’ was regarded as not having any ‘use’ or worth. However, it was unclear as to whether this ‘uselessness’ was configured in relation to the community or a particular group, for example, certain peers (young women who had children or young women of a certain age). Participants often alluded to the community not ‘wanting girls to hurry to the extent of getting pregnant and deliver earlier, ‘ but instead to, resources permitting, ‘get educated, obey their parents, and not get into problems’, such as pregnancy. The following excerpt from an interview with the same young school-going woman as cited at the beginning of this section (on home making), is illustrative of the importance young women appeared to attach to creating a home, as well as speaking further to the notion of ‘pressures.’

Interviewer: ‘[You indicated that] young women at your age [who] don’t want to continue with their school, the most important thing for them is their home. [Where] does this thought come from?’ Participant: ‘This thought comes when they are not happy together at home... […] This sometimes brings about this thought or when she is given much pressure. […] This is when she is having lots of problems at home [...]. The problems can be like abuse, for example, or much pressure.’ [Girl – In School]

When asked about the pressures a family might exert, the young woman explained that it was pressure to,

‘Pay attention to herself [...] so that she thinks about her future not anything else, [...] like the street, random movements, or bad life behavior, [...] life ... early marriage.’ [Girl – In School]

The excerpts above and those in the previous sub-section, together suggest several interrelated issues. They show young women’s struggles in navigating competing social pressures and claims about the appropriateness of their reproductive choices and life decisions. On one hand there is pressure from relatives and family members warning them to ‘stay far away from boys’ following menarche, and from community members expecting them to complete their education first.
On the other hand, there is the peer pressure to obtain the ‘two certificates’ mentioned earlier, and to make one’s own home. These narratives of competing social pressures resonated with the accounts provided by other young women in our study.

Home making: reinterpreting the notion of marriage

A second salient issue with regard to the excerpt given above concerns the question of marriage. According to the young women and men involved in the study, caregivers and the broader community encouraged young people to delay pregnancy (and by implication sexual relations) until after marriage. ‘Marriage’ then seems to be conceived in the conventional sense, that is, as a ceremony marking the formal process of social approval of conjugal relations between a man and a woman. However, the excerpt above illustrates that, in practice, the point at which young people deemed themselves to be ‘married’ and became a husband or wife, was more loosely defined, by young people and to some extent also by society at large; it related to when a young woman/couple became pregnant. The following interaction with a young father shows how the notion of a wife probably had more to do with a girl being the mother of one’s child, and not necessarily about someone is ‘married’ to in the traditional and conventional way – when the interviewer asked about whether boys wanted to be fathers, the young man’s response is about wanting to have a wife.

Interviewer: ‘Are there boys from your group who want to be a father?’ Participant: ‘Yes, it is there, one wants to have a wife … so as to have a child, so that he grows up with him together.’ [Young Father – Not in School]

As another young school going woman relates,

‘Most girls after menarche see themselves as she can do anything, she feels like she is a woman and can handle a home. […] When a girl becomes pregnant she sees herself as a housewife […]. She will feel that she has to become responsible, she has become a housewife who needs to raise her child.’ [Girl in School – With Child]

When asked whether all girls who got pregnant became ‘house wives,’ the young woman clarified that ‘no, […] some end up staying with their parents […].’ The notion of ‘house wife’ appears to be used synonymously with ‘wife,’ with the quotes suggesting that a young woman (and also likely applicable to young men) was only considered ‘married’ when living with the father (or mother) of the child, be it in his family home or ideally – as participants’ accounts suggest – in their own home. Young people, and young women in particular, thus seemed to hold opposing views regarding the desirable route to adulthood when compared with caregivers and the broader community. Whereas the latter set of actors sought to encourage girls to complete their education, and only then marry and have children, many young women regarded pregnancy
as a pathway to establishing their own home with a husband and child. It was this set up that was defined as marriage, and which was seen as offering a means to create (greater) stability and potentially happiness in their lives. As the quote above also indicates, in the local society, menarche thus signals a defining moment of agentic possibility for young women; and getting pregnant, and making a home, are expressions of this agency - the former being a cause for what appears to be considerable concern for parents and health services, but perhaps less so, for peers and the society at large.

**DISCUSSION AND CONCLUSIONS**

The data presented here suggest that for adolescent girls involved in this study, having a child has multiple meanings and represents an attainment – a 'certificate' of much importance. Within adolescent peer circles, and to some extent in the society, in the study area, child bearing signals worthiness – and while our data do not allow a complete understanding of what all this 'worthiness' entails, it does appear to be related to demonstration of one's childbearing potential. Childbearing also seems to provide meaning and satisfaction of achieving something that is valued highly in society, in a context where prospects of achieving something socially valuable through other means, are very few. To adolescent girls, and while it does not emerge explicitly from our data, to adolescent boys too, having a child is also seen as a 'ticket' into the world of adults – having borne a child, irrespective of whether one is married or not, almost appears to be a proxy for being a respectable and responsible adult. Similar findings have been reported by Gyesaw and Ankomah (2013) from Ghana. To some adolescent girls, having a child also opens the prospect of making one's own home. It opens the prospect of exit from households where they are unwelcome and/or in penury, to the security and dignity of one's own home, made together with the father of the child. It follows that given this complex determination, a nuanced view of adolescent pregnancy in South Sudan at public policy and program levels, is warranted.

Having children, many children, is socially desirable in South Sudan. As reported elsewhere, by us (Kane et al 2016) and by El Musharaf et al (2017), for a variety of reasons, great value is placed on a woman's ability to bear children. While adolescent girls’ decisions to bear children is consistent with, and in some ways a reproduction of, this social norm, our findings show that these decisions are also shaped by the harsh economic and social realities which constrain the futures the girls may be able to imagine for themselves. A bleak present and a paucity of viable prospects for the foreseeable future can perhaps also explain why girls choose to get pregnant, somehow betting on and hoping for some financial security from the father, inspite of expectations of their parents and other members of society to the contrary. This exercise of agency by adolescent girls was variously constrained and entailed many personal trade-offs. Between having food and social security now, and hunger and social insecurity now and in the foreseeable future. Between being unwelcome in their current household, and the possibility of leading a dignified life as a wife/mother (traditional forms of formalization of marriage being not necessary, merely being taken in by a male provider being enough). These findings are consistent with a recent survey-based study on adolescent pregnancy in Juba, the capital of South Sudan (Vincent & Alemu 2016).
In the post-war context of South Sudan, the educational system has broken down, while economic opportunities generally, and prospects for adolescents and young adults in particular, are few. In addition, the civil conflict in the last decade has led to widespread displacement, and this has meant that many adolescents have been raised in households with little resources and multiple claimants on these limited resources. While none of the study participants explicitly mentioned that they were unhappy, the desire to leave their current homes, and to forge their own homes, was a consistent theme. Given this context, Hagan and Wheaton’s (1993 p955) argument that ‘researchers give more attention to linkages between particular behaviors within the larger theoretical context of the life course and the social roles of adolescence and adulthood’, as a frame can help provide a more meaningful explanation and understanding of adolescent girls’ desire to have children. It helps one recognize that adolescent’s desire to have children themselves, and their enactment of these desires, might be understood as attempts to escape from the category of the child, and to seek early entry into adulthood. This ‘exit’ perspective can also be understood in relation to the body of evidence (Dillon & Cherry 2014) demonstrating that the presence of ‘aspirations’, and the prospects of opportunities to fulfil these aspirations, are important determinants of adolescents’ reproductive decisions. Such an analytical inference is also consistent with the argument that it is important to pay attention to whether ‘adolescent pregnancy causes poorer life prospects or if poor life prospects motivate early pregnancy’ (Marston & King 2006 p46). Finally, the exit perspective implies that if social and developmental interventions work to create opportunities and lower the barriers for adolescent girls to imagine and strive towards achievable futures, they will make different choices, irrespective of whether they currently have children or not. This analysis is in line with the evidence that shows that interventions that focus on inclusive educational, economic and social development can be effective in alleviating the structural disadvantages that beget adolescent childbearing (Marston & King 2006, Vincent & Alemu 2016, Chant & Sweetman 2012).

At a different level, how pregnancy, childbearing and parenthood are viewed by individuals, and what value is attached to it, at different stages in one’s life as a social being, is a function of the social and gender norms of a particular society (Sudarkasa 1986, Oyewumi 2002). Therefore, it is not appropriate to examine and to simplistically judge the childbearing and parenthood related standpoints of adolescent girls of Wau, as ‘problematic’. Doing so negates the centrality of childbearing and motherhood in the local social and relational context. Doing so also entails unquestioningly assigning victim status to the young women; who, as our findings show, clearly cherish and actively seek motherhood. Examining experiences and standpoints of adolescent girls of Wau through an African feminist perspective (Sudarkasa 1986), allows one to recognize that, despite being severely constrained by complex insecure social circumstances, girls are, in important ways, exercising agency. These findings are consistent with research on early marriage and early childbearing amongst Syrian refugees, who in many ways are in a similar complex and insecure social circumstance (Knox 2017). Extending Vincent and Alemu’s (2016) point, we argue that public health policy makers should make conscious efforts to better understand the experiences and standpoints of adolescent girls, and recognise that in choosing to become mothers, many are exercising agency in complex and unjust social circumstances. Understanding
adolescent girl's motivations will enable policy makers to develop health and social policies and programs which are realistic, and which genuinely contribute to physical, mental and social well-being of adolescents.

Specifically, for South Sudan, social and health development interventions should focus on simultaneously reconfiguring the various aspects of this complex sociality, and on enabling adolescent girls to navigate it, in ways which enable them to imagine the futures they desire, and to exercise agency towards achieving these futures. While it is beyond the scope of this paper to delve into details, drawing on recent reviews (Marston & King 2006 Chant & Sweetman 2012), two social policy avenues deserve attention. One way forward would be to work with the school system to support young mothers and to ensure that they can continue to study and can make informed choices about further childbearing. Such an approach may also offer opportunities to engage constructively with peer norm processes among girls (adolescents, and younger girls). Another important way forward, as detailed in our earlier work (Kane et al 2018a), would be to engage adolescent boys and men around notions of reproductive responsibility in ways such that they can appreciate the broader societal benefits, and their own 'emancipatory interests' (Peace 2014, Flood 2005).

ETHICS AND CONSENT

This study with adolescents was preceded by and linked to a study amongst adults into societal norms and preferences in matters of sexual and reproductive health (Kane et al 2016, 2016a, 2018, 2018a). During data collection among adults, including with traditional leaders, we found that people in South Sudan were very open to discuss these matters. People were eager to be interviewed (and were disappointed when we could not talk to them); many adolescents also wanted to be heard, and local elders urged us to conduct a similar study among the youth. This was reiterated by many during the data validation workshop that was conducted for the study amongst adults, and also by Ministry of Health staff who felt that a good understanding of the perspectives and experiences of adolescents could help make the SRH policies and program more responsive to adolescents’ lived realities.

For consent amongst adolescents, we followed the World Health Organization’s guidance that (WHO Undated), ‘where adolescents are or are about to be sexually active, investigators commit no legal offence in undertaking research that promises a favorable benefit-risk ratio’, and ‘If adolescents are mature enough to understand the purpose of the proposed study and the involvement requested, then they are mature enough to consent’. Further, Bruzesse & Fisher (2003) argue that unlike younger adolescents, those over 16 can make informed decisions as well as adults; others concur (Ruiz-Canela et al 2013) that adolescents above 16 should be allowed to decide for themselves where the risk of harm or discomfort from the research is minimal, and the questions are unlikely to be offensive to most adolescents (this was the case in this study).

The study was approved by the Independent Ethics Committees of KIT Royal Tropical Institute, Amsterdam, and by the Ethics Committee of the national Ministry of Health of the Government of South Sudan. Administrative approval was given by the WBeG state Ministry
of Health. For those participants who could not read, the consent form was read out to them, and oral consent was recorded. All participants were informed of their right to refuse to answer questions they might find intrusive, and to withdraw from the study at any time. In case some participants were to experience some emotional distress during the study, a trained counsellor and medical referral services were available at hand. No such situation requiring counselling or medical referral arose during the study.
REFERENCES


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FINDINGS:
MAKING A CASE FOR THE CRITICAL EXAMINATION OF ASSIGNMENTS OF RESPONSIBILITIES IN THE REPRODUCTIVE REALM: INSIGHTS FROM SOUTH SUDAN
ABSTRACT
Drawing on interviews with purposefully selected informants (n=44) and on focus group discussions (n=5), this article critically examines and reflects upon the gendered assignments of responsibilities in the reproductive realm, in the context of South Sudan. Through this examination, it provides insight into the social practices of assigning and apportioning responsibilities in the reproductive realm; it exposes the nature of social relations, social positions and vulnerabilities they signal, and the normative expectations they communicate, reiterate and reproduce. In doing so the social inequalities and entrenched gendered privileges in the society are made visible. The article argues that the ongoing social disruption in South Sudan offers a unique opportunity for intervening to renegotiate and re-establish a more equitable social compact. A case is made for public health policies to prioritize social interventions which challenge patriarchal privilege without simplistically problematizing men’s roles and actions in the reproductive realm.

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INTRODUCTION

South Sudan is the newest independent nation in the world. More than 60% of the population is below 30 years of age, and approximately 45% are below 15 years of age. It is a large country with many different people (50 different groups), speaking many different languages. The Dinka and the Nuer are the largest group in the country. However, in some states, for example, in Western Bahr el Ghazal State (WBeG), other groups form the majority of the population. In WBeG, the Fertit, the Luo/Jur, and the Dinka are the three main groups. The Fertit are themselves not a single entity but rather are a loose group of more than 23 groups; the major groups include the Balanda (Balanda Boor, Balanda Bviri, Balanda Bagari), the Gollo, the Bai, the Ndogo, the Kresh, and the Njolo. The Fertit predominantly living in the erstwhile Bahr el Ghazal States, and are involved in subsistence farming; this distinguishes them from the pastoralist Dinka and Nuer people. Also, unlike the Dinkas and other pastoralist people of South Sudan (e.g. the Nuer people) who marry using cows as bride price, the Fertit marry through the exchange of agricultural tools (eg. ‘hoes’) and exchange of money (both traditional money and the new paper money). The Fertit people are patrilineal. While each group is unique, there are many commonalities in terms of culture and social norms, between groups. One of the key reasons is that marriages across different Fertit people is common, except that marriage into the mother’s clan/lineage is prohibited. Polygyny is part of the tradition (Seligman & Seligman 1932), and many chiefs and important men continue to have multiple wives. Traditionally, the payment of the bride price by the man’s family relates to the normative expectation that in return, the bride will bear children for the man and his family; in some Fertit people, if in due course, the bride does not bear children, her family would have to return part of the bride price to the man’s family (Seligman & Seligman 1932).

For more than three decades South Sudan has been in a state of conflict: military conflict with Sudan (for independence and later, territorial disputes) and civil conflict between political and ethnic groups in the newly formed nation. Initially, the internal conflict was limited to small parts of the country; however, since 2016, it has spread and has also been marked by episodes of greater violent. The worst hit states have been the erstwhile Upper Nile, Unity, Jonglei and Warrap states; Western Bahr el Ghazal state, the site of this study, has seen comparatively less violence (with 2016 being the exception). While accurate figures are not available, thousands of people have lost their lives, and approximately 4 million have been displaced from their usual places of residence (OCHA 2017). While it is beyond the scope of this work to dwell upon the highly complex internal civil-political conflict, it is worth noting that the conflict is not along the simplistic ethnic lines, as is often reported by international media. Johnson (2016 p.180), in his recent book notes that “despite the ethnic character of the first few months of the war, the South Sudanese as a whole did not respond to attempts at ethnic mobilization”; he goes on to add that “there are signs of hope in the failure of ethnic mobilization”. The ongoing instability and insecurity have led to much of South Sudan’s public infrastructure, including the health infrastructure, being destroyed. In terms of population health, South Sudan is one of the poorest performers in the world. For instance, if one looks at the reproductive health
indicators, it has one of the highest maternal mortality ratios (MMR) in the world (789/100,000 live births), the use of modern contraceptives (as measured by the contraceptive prevalence rate) stands at just 4.7%, and less than 20% of all deliveries are attended by a skilled birth attendant (MOH 2013).

Social and gender relations in society and the norms that shape these relations are important determinants of decisions and actions of men and women on matters in the reproductive realm. A good understanding of these is important for public health policy makers and practitioners to be able to develop and implement context appropriate interventions. With this broad understanding as the starting point, a study was conducted to explore social and gender norms in the reproductive realm among the Fertit people of Wau County of Western Bahr el Ghazal (WBeG) state. The study was a part of a larger project, implemented between 2012 and 2016, that supported the Ministry of Health (MoH) of WBeG state to improve the provision of sexual and reproductive health (SRH) services. Findings from this project have been presented in three earlier papers. In one paper (Kane et.al 2016), we have elaborated upon the complex ways in which social norms shape the child bearing and family planning related decisions amongst Fertit women of Wau. In another paper (Kane et al 2016a), we have discussed the gendered nature of inequalities in the domestic, social, and economic spheres of Fertit society; we show how these inequalities intersect to constrain Fertit women’s agency in the reproductive realm. Drawing on the same dataset, in the third paper (Kane et al 2018), we show the importance of social accessibility of reproductive health services as a key determinant of Fertit women’s use of the available services. While analyzing this large dataset, and in the process of writing these three papers, there emerged in the data, a narrative around reproductive responsibility, its assignments, its upholdment and its abrogation, by men; this narrative related to the themes covered in these three papers, but yet was distinct, and unique. This article critically examines and reflects upon this narrative of men being held responsible for decisions, indecisions, and the related problems in the reproductive realm; and also, how, men, women, and society, normatively assign men the responsibility for solving these problems.

Practices of assignments of responsibility, and narratives of what constitutes ideal conduct (deserving of approval), and what constitutes a deviation from the ideal and the norm (deserving censure, reproof, and blame), represent an intricate social system of mutual expectations and self-expectations. Insight into these narratives and into what it is to be responsible, can reveal how actors in a particular society relate to each other and are bound not just by norms, but also to each other (Korsgaard 1992, Watson 1996; Smith 2015). According to Walker (2007), practices of assigning and apportioning of responsibilities among social actors deserve critical analysis. Her contention is that these practices and the underlying understandings constitute and represent the social structures within which actors interact with each other in a particular social realm; that they connote, reinforce and reproduce social positions of the actors involved. She adds that gaining insight into these practices is critical because the understandings underlying these practices are amenable to change under pressures of several sorts. One key “sort of pressure arises from greater transparency of these understandings themselves and greater clarity about
the costs of reproducing them, or the risks and opportunities of holding each other differently to account.” (Walker 2007 p. 86).

In this paper, we analyze various facets of the practices of assigning and apportioning of responsibilities among social actors in the reproductive realm, in Wau, South Sudan, using Walker’s (2007) frame of analysis. According to Walker (2007), social practices of holding someone responsible entail according that person the status of legitimately embodying that particular responsibility, and/or holding that person responsible for certain forms of conduct. She argues that social actors enact these practices in a particular social realm (in this case, the reproductive realm) by: (1) agreeing to credit certain states of social affairs to be the consequence of human agency; (2) making each other answerable to these states of affairs; (3) setting the terms and conditions for praiseworthiness or blameworthiness, excusability or not, for a particular state of affairs and finally, and (4) “visiting (in judgment, action, speech, and feeling) forms of commendation, or of criticism, reproof, or blame, on those judged in those terms.” (Walker 2007 p100).

Bearing in mind Walker’s point, narratives of ‘responsibility’ in the reproductive realm are examined with a view to understand the nature of social relations, social positions and vulnerabilities they signal, and the normative expectations they communicate, reiterate and reproduce. In doing so an attempt is made to make transparent the social inequalities and entrenched privileges. Instead of focusing on, and simplistically problematizing, men’s roles and actions in the reproductive realm, these narratives are discussed with a view to offer an alternative take on the traditional public health thinking about reproductive responsibility and to identify opportunities for reproductive health policy makers and programmers to meaningfully engage with men.

METHODS
The study population was homogenous in the sense that they were all Fertit. Focus group discussions (FGDs) and semi structured interviews (SSIs) were conducted during field visits to Wau between October 2014 and April 2015. The following groups of informants were purposefully selected for inclusion in the study: married women, 18-35 yrs of age; unmarried women, 18-35 yrs of age; men older than 35 yrs; men younger than 35 yrs; and health workers. One FGD was conducted with each of these groups; in the five FGDs, 38 individuals participated. The homogeneity of participants in each of these FGDs ensured that we could elicit the descriptive and injunctive norms on the study subject. Descriptive norms refer to the beliefs that individuals harbor about a particular behavior in their society, and injunctive norms refer to the extent to which individuals think that key people in society expect them to behave in a certain way.

FGDs were followed by SSIs with community members – the interviews allowed us to probe, and to dwell deeper into participant’s responses and to unpack the descriptive and injunctive norms. FGD participants were not involved in the interviews. In all, 27 community members were interviewed. The following key informants were also interviewed; numbers
of interviews are indicated in brackets: traditional birth attendants (4); traditional leaders (3); health facility personnel (5); state level managers of SRH services (2); representatives of non-government organisations (2).

Community members and key informants were identified with assistance from village elders, local health workers, and county health department staff. The final decision about recruitment and inclusion in the study was made by the researchers. The topics covered in the SSIs and FGDs with community members related to social norms and roles, gender norms and relations, between men and women, and between individuals, family, and society. Questions related to what shapes SRH related decision and actions were also included. The FGDs and interviews with health workers focused on eliciting the perspectives of health workers on the situation and on the views of the community members. The topic guides were prepared in English - they were translated into the local language (Wau Arabic). Interviews and FGDs with community members were conducted in Wau Arabic by researchers fluent in the language; with health and other workers, they were conducted in English.

Data collection continued till saturation was reached, and no further insights were forthcoming. The daily debriefing and discussion sessions (during the field visits) amongst the research team members allowed this assessment to be made on a real time basis. Findings from the larger study have been reported in earlier papers (Kane et al 2016, 2016a, Kane et al 2018). The FGDs and interviews were recorded using a digital recorder. Where applicable, the audio files were translated into English, and verbatim transcripts of all audio files were prepared. One of the authors (MR) and an independent consultant checked the accuracy of the translations. Both are fluent in Wau Arabic, and hail from Wau. Drawing on Braun and Clarke (2006), an inductive thematic analysis of the transcripts was done (Braun & Clarke 2006). The first step involved a thorough reading of each transcript by researchers, in pairs. This was done with a view to identify broad themes emerging from the data. In the next step, through a process of discussion, guided by theoretical and conceptual literature, interpretations regarding the significance of and meanings attached to these themes, and the implications of these themes, were articulated. Through this process, the emerging themes were clarified and refined; in the end, they were appropriately named. All transcripts were coded to the various themes using NVivo 11 software; coding was done jointly by authors SK, MK and MR, during a week-long workshop. One major theme that emerged during the analysis was ‘men and responsibility’ in the reproductive realm. In addition to the text coded to the theme ‘men and responsibility’, the Nvivo 11 software was used (by author SK) to query the transcripts using key words ‘responsible’ and ‘responsibility’ to revisit all moments and contexts within which the study participants used or alluded to these terms.

Ethical Considerations

Informed consent was sought from all study participants. Where possible, written consent was taken. However, since many people in the study area could not read or write, the consent form was read out, and verbal consent was taken instead (and recorded). Given the sensitive nature
of some of the topics, the data collection was done such that privacy and confidentiality were maintained. The data files and the transcripts were also anonymized. Data collection took place at locations preferred by the study participants. Further, answers to questions about expectations from health services and perceptions related to health service delivery, are also sensitive matter, generally, and more so in contexts where there are few alternatives for patients. Given the nature of information we were gathering, protecting and respecting the confidentiality of participants, and ensuring the safety of participants, was a critical consideration throughout the study. All participants were informed about the institutional affiliations of the researchers. Participants were explicitly told of their right to refuse to participate or to not answer specific questions, and/or to withdraw from the study at any time, without reprisal, and of the measures to ensure safety and confidentiality of information provided.

Scientific and ethical approval was provided by two independent Ethics Committees; one from KIT Royal Tropical Institute, Amsterdam, The Netherlands, and the other, the national Ministry of Health of the Government of South Sudan.

FINDINGS
Responsibility assignments and apportionments in the reproductive realm between men and women are presented first; these represent the normative expectations in the study community. This is followed by an analysis of findings which relate to the practices entailed in the social enactment and enforcement of these normative expectations. Social actions and practices that are considered deserving of social approval and praise are discussed first; thereafter practices which are considered deserving of social censure and disapproval are presented. Findings are analyzed with a view to expose the nature of social relations and the consequent vulnerabilities in the reproductive realm in the study community. Finally, findings which signal the dynamic nature of social relations whereby the current responsibility assignments in the reproductive realm are being renegotiated and reapportioned, are briefly presented.

Responsibility assignments in the reproductive realm
In the study community, responsibility assignments in the reproductive realm were central to what constituted being a responsible man. Being a ‘man’ and being considered a ‘good man’ were intertwined with being a ‘responsible man’. And as the following quote from a young woman illustrates, being a ‘responsible’ man not only entailed acting in such manners as to command community members’ respect, but also particularly to having children of one’s own. Conversely, if a man did not have children, he could not be seen to be someone who could be considered ‘responsible’ or respectable.

A good man in the community is responsible. When he is a responsible person … in the community he is well respected and has his children. When a man does not have children, in the community he is seen as not responsible. [Unmarried Woman under 35]

In the following excerpt from an interview, a female traditional leader, while reflecting upon SRH responsibilities and decision making, clearly sets out that in the study community men are the ones with all the responsibility as regards the pregnancy.

If a woman is pregnant it is her husband to take responsibility, the husband has to bring everything. [Traditional Leader Female]

The Sultan (the male traditional leader) goes further with this responsibility assignment, adding that the man is responsible not only for organizing things and caring after his wife, but also for doing so for his sister(s) and daughter(s).

'This' is the responsibility of the person (man) who manages the family. As the person in charge you are like a tree that the family leans on … the rest of the tree depends on you, it is you to decide … You have to organize 'that' with your wife or your sister or even your daughter. [Traditional Leader Male]

In this quote, 'this' referred to all aspects of the reproductive health realm; and ‘that’ referred to shoudering responsibilities related to providing for and taking care of the female family members generally. Study participants alluded to a range of underlying understandings as underpinning this sweeping assignment of reproductive responsibilities to men. At one level, as the following exchange between older women in an FGD shows, study participants talked of the act of impregnation as reflecting men alone exercising agency, and thereby deserving of being held to account for it.

Participant 1: He is the one who impregnated the woman, so he has to take responsibility. He caused the problem he has to solve it. Participant 2: It is the man … yes … the man must take responsibility. [FGD Women above 35]

Similarly, men (and women) explained this responsibility assignment and attribution by offering the explanation that only men could exercise agency in the reproductive realm. This capability logic translated into the social practice whereby men were considered solely responsible for bearing the cost of bringing up children and therefore were the ones liable to be held to account and deemed to be responsible; women in an FGD agreed when one of them said that, "If he decides then they (the wife) can agree. A woman has no decision.". In the same vein, a young man pointed out,

It is the man. … He must tell her the reality that life is difficult. Schools are expensive, and it is good to have sex in such a way that she does not get pregnant. [Young Man]
The above quotes also connote an underlying understanding as to how some men consider that deciding on matters related to seeking care, particularly SRH related care, could not be left to the woman alone. A close look at the findings shows that this understanding had two facets. In the following quote from an FGD, men agreed that leaving pregnancy care seeking to the woman alone was not good; while adding that it was acceptable if she was accompanied by her husband or her mother-in-law. At one level, this can be understood to signal that women's social position in the local society is such that they are not considered capable enough to be 'responsible' or made 'responsible' for such important matters. But since it is acceptable to men if the pregnant woman is accompanied by her mother-in-law, at another level, this could also represent the enactment of the practice of assignment of responsibility for the pregnancy – with the man or his family members being normatively considered the responsible party by the society.

If a pregnant woman is going for check-up she has to go with her husband or her sister-in-law or her mother-in-law … If we leave it to a woman alone it will not be good. In addition, a man should help his wife. A woman alone is not good. [FGD Married men above 35]

The above quote links to the first facet above and exemplifies what Adams et al (1993) call the 'discourse of natural entitlement'. It shows the socially constructed nature of male privilege and conveys how naturalized the notions of male superiority over women are in the local society. The following quote from an FGD among young women illustrates how they relate to this allocation of privilege.

Sometimes the man says he does not have money that was why she could not go for check-up. So, she decides not to go and if the baby dies it is a loss for her husband's family and not her family… [FGD Unmarried women under 35]

Young women assign the responsibility for the welfare of the unborn not to themselves but to the man and his family; this represents a reproduction of the social hierarchies they have been socialized into. The above quote reflects how women see themselves in relation to the men and the unborn child; but far from simply showing passive agreement, it somehow also suggests women's resistance, albeit tacit, to this unfair apportioning of social privilege and contingent responsibilities. Findings, presented after the next section, show how women in the study community are exercising agency to reconfigure responsibility assignments in the reproductive realm.

**Practices of holding others responsible: praising or blaming**

When studying, and discussing responsibility, social theorists refer to what are called ‘reactive attitudes’ — these are reactions that people experience and may or may not express when they
are in situations wherein social responsibilities are assigned, upheld or not, by actors involved in these situations (Strawson 1993). These reactive attitudes are the key elements of the practice of holding others responsible; they can take positive or negative forms. The former entail reactions of approval, admiration, gratitude and the expression of these emotions in the forms of smiles, words of adulation, and other physical gestures. The latter entail reactions of disapproval, resentment, indignation, and the expression of these emotions in the form of disapproving looks, gestural or verbal reprimands and rebukes, in response to wrongdoings or responsibility expectations not being met.

Thus, the practice of holding others responsible entails reacting to certain conduct with praise or blame. Such a reaction may be either expressed or may also be in an unexpressed form. In the following sub-sections, participants’ narratives reflecting reactions of praise/praiseworthiness, and blame/blameworthiness in response to responsibility attributions in the reproductive realm, are presented.

Narratives of social approval and admiration: the ideal ‘Responsible Man’

Participants across the board felt that a responsible man, however young he might be, is someone who would step up and accept responsibility if he had impregnated someone. In the quote below, a traditional leader explains what would be considered socially appropriate and approvable conduct for a boy (while data are not available, a large proportion of teenage boys are fathers in the study community) who had made a girl pregnant,

If he is a well raised up boy he will take the responsibility, he has to come to the meeting with his father, his brother or any elder person in his family. [Traditional Leader Male]

In the interview from where the following excerpt is drawn, a young man articulates what is considered admirable in a man. During pregnancy, a responsible man would take charge, and would ‘supervise’ the women – among others, not only ensuring that she is well provided for, but also making sure that she protects herself and the newborn.

The first responsibility is to be a supervisor. In the first month whether in the village or in the hospital there are things that you stop her from doing. If she drinks alcohol you tell her to stop drinking, if she carries heavy load you tell her not to. [Married man under 35]

These attitudes of admiration for responsible conduct in the reproductive realm, also extended to the broader domestic and family life spheres. In the following quote, an older man echoing the point made by the young man earlier, takes pride in how he conducts himself – reflecting the kind of caring and responsible conduct that is considered praiseworthy in the local society.
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My responsibility in the house is for my wife and my children. As a man I do not want to stray away from my responsibilities or go and find another wife while I have my wife at home. [Married man above 35]

During the data collection and the process of analysis we found that study participants did not have much to say about what conduct and actions were deserving of social admiration and approval in the reproductive realm; they however had a lot to say about what was blameworthy – it was also communicated through non-verbal cues during interviews and FGDs. While in the course of discussing responsibility, and analyzing the practices of holding others responsible, many theorists give similar credence to both positive and negative reactive attitudes, according to Wallace (1996), the negative or other-regarding reactive attitudes of resentment, blame and indignation, presented in this sub-section, and discussed further later, are more important. Consistent with Wallace's (1996) view, as the following sub-section shows, study participants primarily focused their responses on the negatives.

Narratives of censure: of blame/disapproval, reproof, resentment, indignation

A female traditional leader unambiguously laid the blame (consequent on responsibility) for any untoward event during pregnancy, on the man – ‘they’ in the following excerpt refers to all those who will hold the man to account, and them being primarily the woman's family, and also society at large.

Yes, as a man she is your wife […] and if you do not take her to the hospital and something happens it is going to fall on your head. They will ask you … were you taking this woman to the hospital? [Traditional Leader Female]

The male traditional leader, expressing much dismay, also talked of the many complaints he received about men abrogating their responsibilities generally, and in the reproductive realm in particular. As the quote below illustrates, this behaviour was seen as being blameworthy by him, and also deserving of censure.

Interviewer: I have also heard from some women that some men do not take responsibility once they impregnate a woman … what is your view on this? Participant: The truth is … as a chief I hear such complaints a lot. We go and talk to the man and advise him to care … for his children even if the situation is difficult. [Traditional Leader Male]

In the following excerpts, a young unmarried woman, while reflecting on the men who do not take responsibility for the pregnancy, strongly expresses her disapproval and indignation by labeling such men as being poorly brought up - “This is lack of upbringing ... Yes, it is bad
upbringing.” The young woman goes on to mock the manhood of such men, and angrily makes a derogatory comment on the destiny of such men (a ‘nigger’ is a term used by the locals for someone who is considered as being involved in antisocial activities, often violent). Such views were common and strongly articulated by both men and women, the latter in particular.

He sees himself like a man and (yet) he does not take responsibility. And (then) goes to the street to become a nigger and do a lot of bad things, that is it. [Married woman under 35]

Underlying the following explanation given by another young woman, and alluded to by many other female study participants, is both an expression of resentment towards those men who do not uphold their responsibilities, and a resigned acceptance of the social situation they are in.

Interviewer: There are women who would say if you want more children go find another wife … Participant: Yes […] the men nowadays will make you bear a lot of children and they don’t take responsibility. That is why women say go find another wife to give birth to you, me … I am done with childbirth. [Unmarried woman under 35]

Responsibility apportionment in a dynamic context

Walker (2007) has argued that social norms and practices about who is responsible, for what, how, and why in a particular society, are a form of social compact, and are amenable to change under pressures of several sorts. Responsibility apportionments and claims to the social privileges that go with these, are thus maintained only so far as the assignees are able to uphold these responsibilities. Repeated failures to uphold assigned responsibilities, or changes in the context, or a combination of these, open the social compact up, either parts or all of it, for renegotiation. Our findings show that such a process is afoot in the context of our study community. As men fail to fulfil their responsibilities, as the following excerpt from an interview with a young unmarried woman with children illustrates, young women are stepping in and taking charge.

In terms of responsibility, men have no other program than getting drunk […] Women are the ones who have become supportive even to children at home, it is the woman to stand firm and if she does not think about her children the children will be destroyed. If it is food or anything if you are not strong the family will not eat. [FGD Women under 35]

This reconfiguration of practices of responsibility enactment, is echoed by the male traditional leader, who points out how men are failing to uphold their responsibilities, and women are stepping up,
In our community in South Sudan I now see that women are more responsible than men because when you wake up in the morning you see women going to work, to farms, to different places and they are doing better in raising children than men. Because these days people are failing in life and the failure comes from men. [Traditional Leader Male]

In earlier work, we have discussed how in the study community, women expect their pregnancy to be appreciated, legitimated and dignified by the man and his family – among other things, by them taking responsibility for it and showing that by taking good care of the pregnant woman (Kane et al 2018). In the study community, this social expectation was so important that if not met, many women, despite being aware of the benefits of using the services, would choose to forego care and stay at home. However, the situation is changing; women are exercising agency to both reject and resist social expectations. In an FGD among young women, the following interaction occurred in response to a question regarding their views about pregnant women who were not taken in by the man’s family, and who had to raise their children themselves, while living in their parental homes. The interaction exemplifies, how the situation is changing and how women are redefining what is socially problematic, and what is not; it also illustrates how when men and their families fail and retreat from the responsibility assignments, women are stepping in.

Participant 1: It is not a bad thing. Interviewer: It is not a bad thing? Participant 1: Yes. Interviewer: If you are still staying at your home and got pregnant? Participant 2: If the man does not accept you, you will just have the child at home. No problem. Interviewer: No problem with it? Participant 1: Yes. No problem with it. [FGD Women under 35]

**DISCUSSION**

In this section, we discuss what the various practices of responsibility assignments in the reproductive realm, and the related underlying understandings, constitute and represent. By locating and understanding these responsibility assignments within, and as a consequence of, patriarchy and its privileges in the local society, and in view of the evolving social context, considerations that are necessary in envisaging any social change process in South Sudan, are also briefly discussed. A case is made for a pragmatic approach which deliberately and open-mindedly engages with “subjectivities among men that are relational, ethical, and privilege cognizant” (Peace 2014) in the reproductive realm. We contend that while this study was done amongst the agriculturist Fertit people of Western Bahr El Ghazal state, these insights on responsibility assignments in the reproductive realm could be relevant to other similar patriarchal contexts in South Sudan, and beyond.
CHAPTER 7

Social control through responsibility assignments

The many practices and narratives of responsibility are evidence of the intricate social system of mutual expectations and self-expectations in the reproductive realm, in action, exerting to produce the desired social outcomes. At one level, they function manipulatively, exerting pressure on individuals to recognize and perform (to exercise care, to exercise self-control, to put in efforts as appropriate), to meet the socially agreed expectations, and to reproduce conforming behavior. Findings also show that at another level, the practices and narratives of responsibility also function reguatively – serving as injunctive norms (Cialdini, Reno, & Kallgren 1990; Kallgren, Reno & Cialdini 2000), and reiterating understandings of what is required of one by society and how one might be asked to account for it. Practices of holding others responsible are ways by which norms become operative in a particular social realm (the reproductive realm in this case) in a particular society.

As the findings section reveals, such a system of responsibility assignments and the linked practices of social approval and censure, also provides explicit and tacit means, and processes of ensuring accountability and remedies to restore social equilibrium when expectations are not fulfilled, and responsibilities are not upheld (in this case - to ensure that families are taken care of and provided for). These processes need to be deliberately maintained in order for such a system to be able to continue to achieve the desired social outcomes (in this case – men upholding their responsibilities in the reproductive and domestic realms), and also to keep reproducing the specific shared understandings, and the awareness of them as being shared and important.

Responsibility assignments as social structure

According to Walker (Walker 2007), social practices of responsibility assignments, responsibility attributions, and the very usage of the word ‘responsibility’, connote, reinforce and reproduce social positions of the parties involved. The assignment and distribution of responsibilities and privileges within a social realm in a particular society, in large parts also constitute the social structures within which actors interact with each other in that social realm. In the reproductive realm, as the findings show, and as discussed in detail in earlier work (Kane et al 2016), the very structure of patriarchy. When practices and narratives of responsibility reiterate and maintain the shared understandings of self and mutual expectations, they are also reproducing and reinforcing the entrenched social order and relational arrangements in a society. Thus, the system of responsibility assignments and the linked code of expectations not merely operate within, they also constitute the social structure. Unpacking the assignments of responsibility in the reproductive realm in South Sudan, as attempted here, demonstrates, and serves as a prelude to a shared understanding that specific distributions of responsibility to and for persons are made common knowledge, and over time, entrenched within societies – to the benefit of some, and to the detriment of others. Acknowledgement of, clarity and greater transparency about these understandings, is but one of the first essential steps towards social change in the reproductive realm in South Sudan.
Renegotiating responsibility assignments, revisiting male privilege

These assignments of responsibilities in the reproductive realm to men embody the privileged position of men in the study community. As findings show, many men, consciously, and sometimes unconsciously, believe that they are better than women, and that women are capable of and deserving of less. These claims signal a sense of entitlement and this is what constitutes male and patriarchal privilege. These patriarchal privileges are difficult to let go at individual level, and also difficult to undo at societal level. Our earlier work shows that this patriarchal privilege is not without its discontents – it is also considered burdensome by some; a burden which many men struggle to carry, particularly in the changing economic context of the local society (Kane et al., 2016a). The ongoing social disruption and the evolving social and political context of the country offer conditions whereby a new and more equitable social compact can be negotiated and established; intervening to facilitate this process offers a unique opportunity for triggering sustainable social change. To seize this opportunity, a pragmatic approach to engaging men, where entrenched gendered power and privilege are neither ignored, nor essentialised and made the sole point of contention, is called for. Locating and understanding these responsibility assignments within, and as a consequence of patriarchy and its privileges in the local society, and by drawing on the literature on masculinities, allows for a balanced and pragmatic approach; it allows one to reflect on the considerations that are necessary in envisaging any social change process entailed in undoing these injustices.

As part of her broader analyses of the forms of social action towards challenging hegemonic masculinities, Connell (2005 p237) argues that an approach which seeks to involve men in social change policies and programs that challenge entrenched patriarchal privilege, needs to “be compatible with” at least “some of the interests of men”; interests lying “at the intersections of gender with other structures” being particularly appropriate. She however cautions that since men in most societies feel entitled to the “patriarchal dividend” that they accrue by virtue of the entrenched patriarchy, efforts to get men to see shared interests with women may, unintentionally, further entrench gender privilege. Flood (2005), recognizes these tensions, and instead argues for approaches in which men “see their stake in feminist futures”. Such an approach is particularly relevant in the context of South Sudan where one in four women experience some form of gender-based violence daily (Mold 2017). While this study did not focus on gender-based violence and its antecedents, our findings suggest that entrenched patriarchal privilege, amplified and abetted by an insecure context, underpins and explains the impunity with which gender-based violence is committed in South Sudan. Flood’s recommendation that social change intervention approaches be geared towards getting men to “see their stake in feminist futures” is thus very relevant in this context; Peace (2014) goes further and argues that social change interventions need to seek for men to see beyond their interests and to get men to view this social change as being in their “emancipatory interests”. We agree with Peace’s view that men are ethically obliged to change “whether it meets their interests or not”. We also agree with Peace (2014 p551) that efforts need to be put towards developing approaches which engage with “subjectivities among men that are relational, ethical, and privilege cognizant”.
Limitations
Since we did not set out to study responsibility assignments per se, and only during the analysis of the data recognized this theme, many important angles remain to be explored and analyzed. For example, we recognize that there could be differences in the practices and expectations of responsibility of men, depending on the birth order of the child (e.g. first child vs third or fourth child), it could also vary according to the number and order of the wife (polygamy is a very common practice in South Sudan). The article makes a plea to policy makers to take into account the gender power relations signaled by responsibility assignments, in their work. What such policies and strategies could be, has not been discussed in this paper – this is a gap in the literature, and it requires further research.

CONCLUSION
This article, through analyzing the social phenomenon of assignment of responsibilities in the reproductive realm, has explicated and made transparent, the entrenched and unequal social relations in WBeG, South Sudan. Such explications, together with a discussion of the social and health costs of reproducing these inequalities, can help act as pressure for social change. These insights can serve as the starting point for exploring different ways of re-apportioning responsibilities in the reproductive realm, and of holding each other to account differently; the state of social disruption in South Sudan, offers a unique window of opportunity to intervene to initiate such a process. By discussing the findings in light of the broader body of knowledge about social interventions towards challenging patriarchal privilege, this article argues for a relational, ethical, and privilege cognizant approach to reproductive health policy and practice in South Sudan.
REFERENCES


FINDINGS:
TOO AFRAID TO GO:
FEARS OF DIGNITY VIOLATIONS AS REASONS FOR NON-USE OF MATERNAL HEALTH SERVICES IN SOUTH SUDAN
PLAIN LANGUAGE SUMMARY

Years of conflict have led to South Sudan having one of the worst health and maternal health situations in the world. While health services are being slowly rebuilt, many people, including pregnant women, do not use the available services. This study shows that women’s decision to use available services was not merely about whether they were aware of risks involved in pregnancy and childbirth, or about whether the services were reachable, affordable or of good quality. We found that in South Sudan, the social norm is that a pregnant woman is expected to be well taken care of and should be seen to be well taken care of, by her man; the appearance of being well taken care of, socially dignifies the woman’s pregnancy. In view of this, a woman’s decision to seek care during pregnancy and childbirth also depended upon whether in the process of stepping out of her home to go and use services, her dignity as a pregnant woman could be maintained and protected - from the judging eyes of society, other women in the health facility, and while interacting with health workers. Her decision thus also depended upon a complex trade-off she was willing to make between the benefits she thought the care would bring to her, and the potential risks to her social dignity. Explicit attention also needs to be paid to identify, address and allay the fears of dignity violations that may hold women back from using maternal health services in South Sudan.

ABSTRACT

Background

South Sudan has one of the worst health and maternal health situations in the world. Across South Sudan, while maternal health services at the primary care level are not well developed, even where they exist, many women do not use them. Developing location specific understanding of what hinders women from using services is key to developing and implementing locally appropriate public health interventions.

Methods

A qualitative study was conducted to gain insight into what hinders women from using maternal health services. Focus group discussions (5) and interviews (44) were conducted with purposefully selected community members and health personnel. A thematic analysis was done to identify key themes.

Results

While accessibility, affordability, and perceptions (need and quality of care) related barriers to the use of maternal health services exist and are important, women's decisions to use services are also shaped by a variety of social fears. Societal interactions entailed in the process of going to a health facility, interactions with other people, particularly other women on the facility premises, and the care encounters with health workers, are moments where women are afraid of experiencing dignity violations. Women's decisions to step out of their homes to seek maternal health care are the results of a complex trade-off they make or are willing to make between potential threats to their dignity in the various social spaces they need to traverse in the process of seeking care, their views on ownership of and responsibility for the unborn, and the benefits they ascribe to the care available to them.

Conclusions

Geographical accessibility, affordability, and perceptions related barriers to the use of maternal health services in South Sudan remain; they need to be addressed. Explicit attention also needs to be paid to address social accessibility related barriers; among others, to identify, address and allay the various social fears and fears of dignity violations that may hold women back from using services. Health services should work towards transforming health facilities into social spaces where all women's and citizen's dignity is protected and upheld.
BACKGROUND
South Sudan has one of the world’s worst population health indicators; for instance, the maternal mortality ratio stands at 789/100,000 live births (WHO 2015), less than 30% of women are attended to by a skilled health worker; and the rate of institutional delivery assisted by a skilled birth attendant is less than 20% (MOH 2012). In post-conflict contexts, healthcare provision and improving population health outcomes is particularly difficult because of poor infrastructure, limited human resources, and weak stewardship (Roberts et al 2008, World Bank 2011, Haar & Rubenstein 2012). In South Sudan too, the long-drawn conflict has weakened the health system, and there are severe shortages of health workers and few well-functioning health facilities (MOH 2012). De Francisco A et al (2007), drawing on the International Covenant on Economic, Social and Cultural Rights (World Health Assembly Undated), argue that for public health programs to be useful to and to be used by the people they mean to serve, one “requires location-specific investigations” (p19-20). In a recent review of maternal and child health policies in South Sudan, Mugo et al (2015) noted that “Informing policy with evidence requires acute sensitivity to local context”; in a subsequent paper, they further emphasize the need to “address the socio-economic factors that prevent women from using maternal health services” in South Sudan (Mugo et al 2016). This paper presents the findings of such an investigation from South Sudan; it complements the recent work by Mugo et al (2015a), Wilunda et al (2016), Lawry et al (2017) on barriers to maternal health in South Sudan.

This paper reports findings from a study done within the context of a project designed to support the Ministry of Health (MoH) of Western Bahr el Ghazal (WBeG) state of South Sudan to improve sexual and reproductive health (SRH) service delivery. There is robust evidence that “A health centre, intrapartum-care strategy can be justified as the best bet to bring down high rates of maternal mortality” (Campbell & Graham 2006); the project, among other things, explicitly focused on improving access to and use of maternal health services. Within the operational research component of the project, a range of questions regarding SRH related behaviors and decision making were identified and studied; one of them being ‘why inspite of having maternal health services in the vicinity, many women still do not use the maternal health services?’.

Findings from the broader study are reported in earlier papers which report how social norms and gender norms shape procreation decisions, birth spacing and family planning related decisions in South Sudan (Kane et al 2016, 2016a). Wilunda et al (2016) and Lawry et al (2017) in their recently published papers, elaborate upon geographical, financial, security and cultural barriers to the use of maternity services in South Sudan. These barriers also featured prominently in our study findings; however, we also identified other ‘social’ reasons why many women, do not use, or hesitate to use, the maternal health services currently on offer in Wau county of WBeG state of South Sudan. In this paper we focus on these ‘social accessibility’ (Powell 1995) related barriers. We do so to highlight the importance of this usually neglected dimension of accessibility, and in the process, we contribute to extend our understanding of what all ‘social accessibility’ could entail.
METHODS

A qualitative study was conducted; data was collected through focus group discussions (FGDs) and semi-structured interviews (SSIs) conducted with a variety of purposefully selected informants, as detailed in Table 8.1. Following sections further explain the sampling and recruitment principles and processes.

Topic guides for FGDs and SSIs were developed using de Francisco et al's (2007) conceptual framework. According to the framework, individuals and social groups occupy positions of relative advantage or disadvantage with respect to their access to resources (social and material), within overlapping spheres of influence: the household, community, larger society, and the political environment. Individual’s and social groups’ position and relations in these overlapping spheres of influence shape their SRH related decisions and actions. Topic guides for community members included questions exploring people’s expectations from, and reasons for (non-)use of maternal health services. The topic guides for health and other workers included questions on the same lines, but with a view to explore their perspectives on the (non-)use of maternal health services. The FGD and SSI topic guides for community members were prepared in English and translated into the local language, Wau Arabic. The topic guides were defined further during the initial stakeholder workshops, pre-tested in the study site, and were adapted iteratively as the study progressed.

Study sites

The study was conducted in Wau County of WBeG State of South Sudan. While South Sudan is home to more than 50 ethnic groups, in WBeG, the Fertit, an agriculturalist people, predominate. Two locations in Wau County were selected based on the homogeneity of the residents (all Fertit). Both locations were within walking distance of functioning maternal health services - this was important as health service coverage (geographical) is poor in many parts of WBeG. In both the locations, maternal health services were provided in a primary care facility staffed by one clinical officer, one nurse, 1-2 midwives and a pharmacist. In both facilities, the staff were a mix of locals, and returnees who originally hailed from WBeG. The two locations represented two different settings in Wau County – Wau town and the other a rural area. However, in both settings the socioeconomic situation was similar, with most people engaged in subsistence farming or informal manual labour. The assumption behind choosing these two locations was that perhaps within the same ethnic group, depending on the setting, the decisions and decision-making processes around whether or not to use maternal health services, might be moderated differently.

Sampling, recruitment of study participants and data collection

Details of study participants are presented in Table 8.1. Community members were purposefully selected with the assistance of village elders, health workers from a local NGO and the county health department. The assistance was limited to guiding the researchers to the village and to making introductions; the actual selection was done by the researchers themselves. Amongst
community members, only those of age 18 years and above were included in this study. We purposefully categorized participants into those between 18-35 years and those above 35 years with the assumption that the two age groups might have different health seeking behaviors.

Data collection began with FGDs amongst community members, followed by SSIs to obtain more in-depth understanding. FGD participants were homogenous in terms of ethnicity, age and marital status, yet diversity was sought in terms of social and economic status (criteria included ownership of assets like bicycles, and level of education).

Health facility personnel responsible for maternal health in facilities close to the study sites were included as participants. Individuals with active maternal-related role within the county and state health system i.e traditional leaders, traditional birth attendants, SRH service managers, and representatives of NGOs working on maternal health, were also included as key informants. Data were collected from October 2014 to April 2015, over 3 visits to Wau. FGDs and interviews with community members, traditional leaders and traditional birth attendants were conducted by research team members who hailed from the study area, were fluent in Wau Arabic, and had experience with conducting qualitative research. Data were collected till analytical saturation was reached, and no new insight emerged; this was possible to assess, as at the end of each day of data collection, the research team debriefed and discussed the emerging findings. In total 5 FGDs (with 38 participants) and 44 SSIs were conducted.

Table 8.1. Overview of study participants and data collection.

<table>
<thead>
<tr>
<th>Method</th>
<th>Profiles of study participants</th>
<th>Number of activities (# of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Community members: Female 18-35 years (Not in union*) 1 (8)</td>
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<tr>
<td></td>
<td>Community members: Female 18-35 years (In union) 1 (8)</td>
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<td></td>
<td>Community members: Male &gt; 35 years 1 (8)</td>
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</tr>
<tr>
<td></td>
<td>Community members: Male 18-35 years 1 (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health workers 1 (6)</td>
<td></td>
</tr>
<tr>
<td>SSI with community members</td>
<td>Community member: Female 18-35 years (Not in union) 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community member: Female 18-35 years (In union) 6</td>
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<td>Community member: Male 18-35 years 6</td>
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<td></td>
<td>Community member: Female &gt; 35 years 6</td>
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<td></td>
<td>Community member: Male &gt; 35 years 4</td>
<td></td>
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<tr>
<td>SSI with key informants</td>
<td>Traditional birth attendants 4</td>
<td></td>
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<td></td>
<td>Traditional leaders 3</td>
<td></td>
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<tr>
<td></td>
<td>Health facility personnel 5</td>
<td></td>
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<tr>
<td></td>
<td>State SRH managers 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NGO representatives 3</td>
<td></td>
</tr>
</tbody>
</table>

* Participants were either In Union or Not In Union at the time of the study. Relationship status is presented this way because in Wau people say they are married only if the relationship was formalised either in a traditional ceremony, or in the church – even if they cohabit. For convenience we use the terms married/unmarried in the paper.
Data Analysis
SSIs and FGDs were digitally recorded, translated from Wau Arabic into English (where applicable) and transcribed verbatim. An inductive thematic analysis of the transcripts was conducted (Braun & Clarke 2006). Analysis began with an initial thorough reading of transcripts by three researchers (SK, MR, MK) to identify broad themes about the reasons for use or not of maternal health services. The guiding principle in this process was to identify the various reasons that were important to participants and to ascertain that the chosen themes captured the main aspects of participants’ reasons behind using or not using SRH services. The next step involved moving from these themes to an interpretation of the broader significance of and meanings attached to these themes, and the implications of these themes; in parallel, and iteratively through this process, the identified themes were reviewed, refined, and named. The NVivo 11 software was used to code all transcripts and to run queries on the dataset. Findings from the preliminary analysis were refined through follow up interviews with 2 participants in each study site (n=4), one traditional leader, one local resource person, and through a workshop involving community health workers, health facility personnel and SRH services managers (n=13).

Ethical Considerations
Informed consent was given by all study participants; for those who could not read, the consent form was read out to them and their consent was recorded. Confidentiality was maintained throughout, and steps were taken to anonymise the data and to minimise risk of accidental disclosure and access by unauthorized third parties. Since the study included questions about the local health services and the responsiveness of providers, special care was taken to ensure that identities of participants were not revealed to the local health workers. All participants were explicitly informed of their right to refuse to participate and to not answer questions they might find to be intrusive. Keeping in mind the possibility of some participants being reminded of traumatic experiences, medical referral services and counselling support were made available. No such situation requiring referral emerged during data collection or in the period after the study.

RESULTS
While the study did not dwell into the details of level and nature of knowledge about SRH matters, all community members – women and men across age groups, and all traditional leaders, recognized the benefits of modern maternity care, and were aware about the importance of antenatal care, institutional delivery, and to some extent, post-natal care. Reliable, state and county level data on availability, accessibility and utilization of maternal health services is not available in South Sudan. However, in the study area, services were available and accessible; and study participants indicated that they appreciated the presence of these services and used these services. Issues related to geographical access, financial access, and perceived quality of care were reported as being important barriers to the use of services by our study participants. These
barriers are important; however, they are not the focus of this paper, and hence not presented and discussed here.

This section presents other social reasons why inspite of being knowledgeable about and having maternal health services in their vicinity, many women still did not use these services. Findings are presented as themes; three major themes emerged. The first theme presents how various social fears shape women's care seeking. The second theme presents how women's social expectations and social interactions around the act of visiting a health facility shape their care seeking behavior. In the third theme, women's and society's views about pregnancy are presented with a view to locate the findings of the first two themes in the local context, and to better explain them.

**Social Fears**

Women, both young and old, talked of fear and of 'being afraid' in some form or the other. They often did so without probing, indicating that the experience probably had wide relevance, and was an important feature of women's interaction with the maternal health services, specifically of why women, used the maternal health services, or not. The importance of this cognitive process was acknowledged by professional informants too; although their observations were limited to and primarily referred to fears related to painful medical procedures and to the insecurity involved in the act of travelling to health facilities.

**Fear of being embarrassed**

Women were afraid of being embarrassed during the care encounter; in our study, this feeling had two broad facets. One related to not having enough money to cover the expenses incurred, and another related to not having one's husband by one's side.

Maternal health services in South Sudan are free in primary care facilities, although some user fees are levied in hospitals. However, the facilities in the study area often did not have enough supplies and drugs; patients were asked to buy these from private pharmacies. In Wau, people had to spend money to buy goods (soap, cloth, cotton, medicines etc) that are needed when delivering in a health facility, for transport, for stay if one were from another place (as is often the case around Wau), and also to pay for fees (including for informal payments to health workers). Not having enough money was clearly cited as a reason for not using services by both men and women. As the following quote illustrates, one of the underlying mechanisms through which not having money also shaped care seeking decisions, was that women were afraid that if they were to be asked to pay, and they did not have enough money on them, they would be shamed or even be belittled.

It might be money, some things go back to the economy, maybe there is no money and she is afraid that when she goes they will charge her a lot of money. [Woman under 35, Not In Union]
Another underlying mechanism through which not money affected care having seeking decisions, was that women were afraid that if they did not have enough money to pay for the expenses incurred at the hospital, they might not be allowed to return home. This led some to not only not use the hospital facilities, it also led them to turn to (and often to prefer) the services offered by traditional birth attendants (TBAs). Unlike hospitals, TBAs were flexible; they did not necessarily expect cash, and could be paid in instalments, over a longer period of time.

TBAs can wait even for a year for the women to pay them, but if you go to the hospital and you don’t pay they won’t let you go home, so women fear. [FGD, Women above 35]

Women who were widowed, or did not have a husband, or whose husband was away, or had been abandoned the husband, or had no family to support them, were afraid that health workers would ask them about their husbands and would insist that their husbands be present. In South Sudan, a pregnancy is a matter of pride, and it is important that it is dignified by and seen to be valued by the man and his family. It is deeply embarrassing to women if they are seen to be on their own, and with no man to dignify their pregnancy. Women fear this embarrassment, and instead of going to health facilities, prefer to stay at home to avoid the embarrassment.

She is also afraid that they might tell her to bring her husband … and the man is not there. Because of fear they stay at home [Woman under 35, Not in Union]

For such women, as was often the case, not having enough money, further amplified the problem. They were particularly worried that if they did not have enough money on their person, the health workers might ask them to bring their husband, further exposing them to embarrassment.

Fear of being ill-treated
There is a large body of literature from low and middle-income countries which documents ill-treatment of patients by workers in health facilities. To some extent, and linked to the fear of being embarrassed, women in the study community were also afraid of the midwives being rude to them. In the following quote, a young woman points out how some women are so afraid, that they would rather deliver at home, inspite of knowing well that to do so, is dangerous.

The people who do not want to go to the hospital are people who are afraid. They fear delivery, and fear that the midwives will be rude to them. So that is why they don’t go to the hospital but still deliver at home ... (even when they know that it) ... is dangerous. [Woman under 35, Not in Union]
Senior health workers and SRH service managers, recognised this situation. They were well aware of and felt ashamed about the poor attitudes of some of their staff. Privately, some expressed frustration at the situation – pointing out that the shortage of health workers in the area meant that they had very little room to reprimand and discipline the errant health workers.

Yes, I do agree, this situation is very embarrassing … some midwives are verbally abusive and have bad attitudes. Some women will prefer not to come back to the hospital because of the maltreatment. [Health Facility Personnel - Manager]

**Fear of being denied services**

Many steps are being taken to improve maternal health services in South Sudan; for instance, to improve the continuity of care, a paper card is issued to every pregnant woman. In this card, health workers record the progress of the pregnancy and the pregnant woman's medical situation. We found that health workers diligently use these cards and impress upon women the importance of carrying these cards when they visit health facilities; most women also understood the importance of these cards. However, it was these very cards that paradoxically appeared to hinder the use of maternal health services. Some women could not afford these cards (approximate price= 0.25 EUR), and therefore hesitated to visit the health centres. We found that many women lost their cards, had their cards torn, or soiled; as the following quotes show, women in such situations were afraid of being reprimanded by the health workers, and denied services.

This will affect you, if you have a child (are in the process of delivery) and you do not have a follow up card no one will accept you even the trained midwives they will not assist you. Even the hospital will not accept you. [Woman under 35, Not in Union]

If the midwife finds that you do not have a hospital card, she will tell you that she cannot go to you because you did not go for checkups. If a crime comes to me, what will I say? I will not go to you. We have this kind of situations here. [FGD, Women over 35]

These quotes also illustrate how the way these check-ups and cards related processes were implemented in practice, perhaps unwittingly, paradoxically gave some women the impression that not carrying these cards, or not attending earlier antenatal check-ups, was akin to committing a crime. An impression that seemed to be enough to make some women afraid, and to not use maternal health services.

**Insecurity related fear**

Poor rule of law is a problem in much of South Sudan. The state apparatus is unable to protect people from antisocial elements, including but not limited to ethnic militias. The prevailing
insecurity featured prominently in both men and women's explanations for not using health facilities. People were afraid of being accosted on the way to the health facilities at night, but also during the day.

If labour pains start at around 2 am, and there is no way to go to the hospital, and there is no transport, and you fear criminals on the way. [Woman under 35, Not in Union]

There is no transport, so people fear to move at night to go to the hospital and people can attack you on the way [FGD, Men under 35]

The health workers, the healthcare managers all admitted that this was a major problem. They acknowledged the circumstances and they recognized people's fears as understandable, pointing out that this was the price society paid on a daily basis for the chronic insecurity and unrest.

And for people to access services there must be security, people should have peace of mind that if I walk five kilometers, I will go and come back without any problem. So, one of the factors is ... if I go there and I feel threatened (on the way to getting to the facility), it will affect the utilization. [NGO Representative]

The findings above reveal that a variety of social fears also shape decisions around seeking maternal health care. In the discussion section, these fears, and the social processes driving them, are discussed in view of the theoretical insights on 'social fears'.

Dignity expectations not being fulfilled
In the study community, as in all communities in South Sudan, pregnancy is a matter of personal pride for women. It is something to be celebrated and dignified by the man's family. As the following quotes from an FGD among men illustrate, it is expected that a pregnant woman is treated nicely and is seen to be so too in society, particularly when she ventures out of the house and into public spaces.

When you (a pregnant woman) get up to go to the health center, the culture and traditions are like ... the shoes on your feet and the clothes ... when you want to leave your house, you need to take a shirt and wear (good clothes). [FGD, Men over 35]

Being able to dress nicely, and to be presentable in public spaces like the clinic, was very important to women. It was important to the extent that if they did not have soap to bathe and did not have a clean dress to wear, they would rather not go to the clinic – inspite of knowing well the importance of the antenatal, natal or postnatal visits.
When they get pregnant, they want their husbands to buy them new dresses, new shoes, to braid their hair … and to give her money … then after … that is when you leave home and go (out into public places, like the health centre). [Woman under 35, Not in Union]

Women whose husbands were either away, or who had been abandoned by their husband, or had nobody to provide for them, would rather not be seen in public in an unpresentable state. Appearing disheveled and uncared for would give people an impression that this was someone whose pregnancy was not being celebrated and dignified by the family. Women in such circumstances would rather forgo care, than open themselves to dignity violations. While reliable data are not available, many women in the study community, and in South Sudan at large are in such a situation.

The ‘pregnancy’ - for the man’s family, and also the man’s responsibility

In some ways linked to all of the above themes, and in many ways shaping women’s care seeking decisions and actions, albeit at a cognitively different level, is the status and role of women in the local society, and how women see themselves within and interact with these social arrangements. We found that women’s role in society is seen to primarily be about bearing children for the man’s family. The entrenched social norm is that women must bear as many children as the man and his family members wish; this norm relates to the idea that children replace the dead, and they allow inheritance and the continuation of the man’s family name. The following two FGD interactions illustrate the local social reality and how men and women relate to it. The first interaction below, in an FGD among young women, illustrates how women see and experience their situation and role in the man’s family; it also highlights how not bearing children as demanded by the man and his family, incurs the risk of being abandoned by the man.

Participant 1: If you are married and already living with your husband and do not have a child, the husband can leave you and tell you to go back to your family. Participant 2: His relatives will come and argue that why you are not getting pregnant … the man’s relatives will complain why is this woman brought and eating our food for free if she is not going to deliver children. Participant 1: The relatives will tell the husband to leave you and go and get another woman who can have children. Participant 3: Or the (man’s) relatives themselves will go and get a wife for their son. [FGD, Women under 35]

The second interaction below, in an FGD among men, men nonchalantly discuss their inalienable claim on the woman’s womb and her fertility potential. They refer to the woman as ‘our’ wife – it signifies not just the man’s claim, but rather the family’s, for they have bought her, and brought her into the family, with the purpose of bearing children for the family. The discussion shows how the man, and the man’s family not just expect the woman to give them children, her not doing so, is considered sufficient grounds to abandon her and replace her.
Participant 1: Because this is our wife, we married her with money. Of course, marrying a woman is like business … is like business. Meaning that if you start a business you must profit from it. Participants 2,3,4 (In chorus): Yes, Yes. Participant 1: And if you take a woman with money and she does not give you children, that is not good. Participant 2: Yes, the family … if a woman is pregnant your family is happy. Participant 3: They will say that this woman is now giving birth replacing the person who had died … the one inside now is in place of the person who had died. The family will be happy. Participant 4: Like … this is my son here. He married a woman. His wife is bearing children. I will be happy. Some people meet me and say … Oh Peter! Your son's wife delivered. I'll be happy... But if my son married a woman and she does not bear a child, eating the 'Asida' (food) for free, I will not be happy. [FGD, Men under 35]

Women’s awareness of their status in the man’s household, and their cognizance of the social reality that they had been brought (even, bought) into the man’s household to bear children, appeared to result in an ambivalent attitude towards pregnancies generally, including towards their own pregnancy. This layered sociality also shaped women’s approach towards using maternal health services. Women seemed to view the (unborn) child as the man’s family’s, and also seemed to view the process of using maternal health services as not being about their own health, but rather being about the health of the (unborn) child, and thus the responsibility of the man and his family, and not their own.

Facilitator: Some women do not go to the hospital what makes them not to go?
Participant: Sometimes the man says he does not have money that was why she could not go for check-up. So, she decides not to go and if the baby dies it is a loss for her husband’s family and not her family. [FGD, Women under 35]

That having been said, this approach to pregnancy and maternity care was not universal. Many women, even when their husband did not provide them with the money, still used antenatal and delivery services; they did so through raising money from other sources. In such situations some women also resorted to using the services offered by traditional birth attendants who charged less, were open to being paid in kind, and to being paid in instalments.

DISCUSSION
Consistent with Wilunda et al. (2016) and Lawry et al’s (2017) studies from South Sudan, and the global health services literature (Say & Raine 2007, Gabrysch & Campbell 2009), our study also found that women do not use the services, if they don’t feel the need, if services are inaccessible (geographically and financially), if they perceive services to be of poor quality, and if they do not have confidence in the competence of providers. Instead of repeating what Wilunda et al (2016) and Lawry et al (2017) have reported in detail, in this paper we choose to focus upon an important, and often insufficiently reported dimension of access – ‘social accessibility’ (Powell 1995). In the following discussion section, we draw upon our insights about the context
of South Sudan, theoretical insights, and empirical findings from literature, to discuss our findings about women's views on pregnancy, women's dignity expectations, and social fears around the act of seeking care. In doing so, we also extend the conceptual understanding of what constitutes accessibility of services, specifically the notion of 'social accessibility'; we make a case for inclusion of this understanding when studying access to services and when intervening to improve access to services.

We begin with a discussion on what we consider a meta construct shaping women's thinking about pregnancy, and their approach to dealing with it. This background sets the stage to further discuss our findings within two broad and linked theoretical frames: social fears, and social dignity and its violations. Throughout the process, implications are drawn for public health policy and practice in South Sudan, and where appropriate, beyond; in the process, we add to and nuance this body of knowledge on multiple fronts. In doing so, the importance of 'location specific investigations' recommended by De Francisco et al (2007) and others (Mugo et al 2015), is reiterated.

Carrying a child for someone else
Women's ambivalent, sometimes even uncaring attitudes towards pregnancies, including their own pregnancy, need to be understood better. Oyewumi's work (2011) on family structure and social relations in many African societies, provides a useful frame to understand this ambivalence; according to Oyewumi, in many African societies, the family unit is a “consanguinially-based family system built around a core of brothers and sisters-blood relations, wherein the spouses are considered outsiders and therefore not part of the family” (Oyewumi 2002). This is unlike the Western family structure of a conjugally-based family built around a couple. In many communities of South Sudan, including in WBeG, the family unit is a consanguinially-based unit, and the woman remains an outsider whose primary role is to bear children for the man's family. This family structure and the social norms that accompany it, in some ways explains why many women viewed the child they were carrying as someone else's and for someone else, and its care was thus also seen by them as being someone else's responsibility – the someone else being the husband and his family. We argue that these social relational arrangements shape how women view and relate to their own pregnancy, and also what they are willing to do or not do, about it. These social-relational arrangements thus constrained women's use of maternal health and SRH services. Pregnant women seemed to also somehow use these social arrangements as a rationale to justify their actions or inactions, which they well knew as being not good for the health of the unborn.

Social Fears
'Fears' of different kinds emerged as a key concern shaping the non-use of maternal health services. Findings show that the broader theme of 'social fears', is constituted by and subsumes sub-themes which reflect a wide range of social processes: unequal power relations between providers and patients, professional control over the patient-provider interaction and the linked sense of undermined agency, and the broader insecurity in region and country. The latter
being a fear, but also perhaps an enabler of other fears; insecurity tends to undermine use of services through, among others, pushing up opportunity costs of accessing services. These sub-themes not just represent different facets of social fear experienced by women when interacting with or contemplating the use of maternal health services, they also help explain how the fear experience is mediated in a number of specific social contexts, and shapes women’s decisions to use maternal health services.

Drawing on Tudor (2003), we argue that the many fears articulated by women are perhaps best understood as ‘social fears’, where they relate to and are shaped by the attributes of the social worlds individuals inhabit. Social fears may be explicit or tacit, big or small, but they pervade all aspects of our lives and are a key feature of many social situations and interactions; Tudor argues that these fears featuring within social situations “have complex ramifications for the ways in which we live our lives”. If one’s environment, and social interactions repeatedly signal that a certain kind of activity or interaction is unpleasant, painful or dangerous, and could lead to trouble, and if these signals are experienced by others in one’s environment, then this provides the conditions for fear to emerge for that particular activity or social interaction. Such fears, once established, have a powerful effect on the actions of individuals. Women who harbor fears, however big or small these fears might be, are unlikely to easily use the maternal health services on offer; furthermore, if sufficient number of women harbor such fears, it influences the thinking of others around them. Evidence shows that experts’ and professionals’ control over many areas of human activity, like healthcare, can promote fear also beyond the worries related to the direct consequences of specific actions and interventions – including, as in this case, rude/abusive behaviour (Bohren et al 2015, Chi et al 2015). It can partly also explain why many women turn to and prefer traditional birth attendants.

Discussing the care experience of study participants within a relational context can help better understand the last point regarding the returnee care providers. In South Sudan, including in Wau, the relations between the locals who stayed behind during the war, and the returnees who had fled to the erstwhile Sudan during the war, are tense. The returnees have brought valuable knowledge and skills back with them; however, many returnees, because they have been away for decades, do not identify sufficiently with the locals, and tend to be judgmental of the locals. While on one hand the locals welcome and appreciate the returnees, they are keenly aware of the subliminal othering effected by the returnees. This, together with the underlying feelings of resentment amongst those who stayed, towards those who went away, makes the interaction between the locals and the returnee providers, complex, and presents a fertile ground for manifestation of fears. That said, the social dynamics between the returnees and locals was not the focus of our study; further investigation is needed to understand it and its possible public health implications.

Social dignity and dignity violations

Women’s decisions to step out to seek care are the results of a complex trade-off they make or are willing to make between potential threats to their dignity in social spaces, their views on ownership and responsibility for the unborn, and their fears regarding the care encounter. Many
of the fears expressed by women are perhaps better understood in terms of them being afraid of their dignity being violated in the various interactions entailed, and the spaces traversed, in the act of seeking care. We draw upon the notion of social dignity (Jacobson 2007, 2009), the social and cognitive processes around its maintenance and its violations, to better understand our major findings. Social dignity as a concept refers to the idea that in every social interaction, the dignity of one or more participant or bystanders, can potentially be upheld, promoted, threatened or violated. What entails social dignity, and perceptions of when it is upheld, threatened or violated, is socially constructed – it depends on the norms and traditions of a particular community or society. The socially constructed nature of social dignity means that people in every society have tacit knowledge of how to assess it, when to expect its violation, and when to expect its upholdment. For a social interaction to become a dignity violation does not necessarily require explicit action or words being said, it can simply be an act of interpretation by the one whose dignity is at risk, or by others involved in the interaction, including the bystanders.

Consistent with the global literature on dignity and healthcare services (Chi et al 2015, Freedman & Kruk 2015, Miller et al 2016), women in our study reported being afraid of how they might be treated by healthcare workers in their care encounters. The mechanism underlying this fear of being abused, being reprimanded, being shamed, or being belittled during the care encounter, was fear of their social dignity being violated. This concern with social dignity, and its risk of being violated was however not restricted to the care encounter alone; women accorded great importance to and were concerned about how they were seen in public spaces, be it on the way to the health facility, or in the health facility premises. These spaces were arenas for social interactions where community members, primarily women, asserted their social standing in relation to others. Those pregnant women who could not dress up and look nice and be seen as being well taken care of, often preferred to stay at home and not seek care, to protect themselves from the judging eyes of other women and society at large, thereby guarding their social dignity. Not having the means to meet the social expectations, socially enforced or imagined, was a reality for most women in the study community. If a woman is in a position of vulnerability, she is more likely to interpret even a relatively minor social slight as violation of her social dignity (Jacobson 2007, 2009), and as discussed earlier, if the woman happens to see the process of making herself vulnerable to such a violation as not being in her benefit or her responsibility, she will avoid even initiating the process of seeking care. Jacobson (2007) argues that in difficult circumstances, some, particularly those who are most disadvantaged and vulnerable, may be so worn down by the constant micro insults and violations of their social dignity, that they may isolate themselves and avoid social interactions as much as possible – these manifests as “a reluctance to seek help or access resources, passivity or ‘learned helplessness’”. Many women in our study community, and in many parts of South Sudan, are in such a position.

LIMITATIONS
The study has some limitations. There was a possibility that people would only give socially desirable answers with the view to not antagonize health workers. These constraints were anticipated, and steps were taken to loosen these constraints. Data collection with community
members was done by researchers who hailed from the local community, were independent, and were in no way related to the NGOs delivering services. They also knew the local culture well and took due care to ensure frank and open interactions. Visits were made to the study sites before the actual data collection to meet the villagers and the elders – to explain the nature of the study, to seek the village’s agreement for our presence, and to reassure them that confidentiality will be maintained. We observed that participants were eager to participate and happy that they were being heard. Throughout data collection, the interactions with participants were frank and candid; it makes us confident about our study findings.

CONCLUSIONS
Barriers related to geographical accessibility, affordability, and perceptions (need and quality of care) hinder women from using maternal health services, and these barriers need to be addressed. Through this paper we show that it is equally important to also explicitly consider, and address barriers related to social accessibility – our findings highlight how social fears and fears of dignity violations may hold women back from using maternal health services. We argue and conclude that interventions to improve accessibility of maternal health services should have features that protect women from dignity violations in the care encounters and should make and shape health facilities into spaces for dignity promotion, for one and all.

Making health facilities into spaces for dignity promotion requires the explicit embedment of dignity considerations in all aspects of service organisation, across provider-patient encounter settings, and across the health facility as a social space. Specifically, and drawing on Jacobson (2009), among other things, this could entail the development of a local diagnostic tool which allows service users and practitioners to jointly reflect on “their own positions of vulnerability and antipathy, and on the nature of the gestures, interpretations, and responses that constitute dignity violation in their own settings, using this exercise to change the dignity dimensions of their interactions”, and of the spaces in which these encounters occur. Doing so will not only draw women to health facilities, it can also contribute to broader social cohesion and social development by signalling social equality regardless of ethnicity, social and economic status.

Dignity violations in the healthcare encounter and in the health facility space are but reproductions and manifestations of the structural inequalities prevalent in a society. These structural problems require structural solutions at the societal level. While these solutions are beyond the purview of health workers, public health programs and health workers can contribute to triggering social change by both, changing things in the health facility and creating exemplar islands of possibility, and also by actively making common cause with those who are working on promoting social justice, rule of law, and tackling gender and social inequalities in the society.

DECLARATIONS
Ethics and Consent to Participate statement
The study was approved by the Independent Ethics Committees of KIT Royal Tropical Institute, Amsterdam, The Netherlands vide letter dated 12th June 2014. The study was also approved by
the Ethics Committee of the national Ministry of Health of the Government of South Sudan, vide letter dated 2nd October 2014.

Consent to Publish statements
Not applicable.

Competing Interests
All authors declare that they have no competing interests.

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Author’s contributions
SK is the Principal Investigator. SK, MK, MR collected and analysed the data. SK drafted the manuscript. MK, MR, MD, JB reviewed the draft manuscript and gave inputs. SK finalized the manuscript. All authors have read and approved the final manuscript.

Availability of data and materials statement
The data is in the form of verbatim transcripts. It will not be shared publicly as the study participants have consented only to the inferences drawn in this and earlier papers; they have not given consent to share the raw data.

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REFERENCES


DISCUSSION AND CONCLUSIONS
This chapter begins with a discussion of the study findings presented in Chapters 4-8. While each of these five chapters addresses one specific research question, in this section the discussion is structured such as to reflect on the emerging cross-cutting findings and how they relate to the overall question. Overall, the discussion chapter mirrors my evolving understanding of social norms and their relation to human behavior, particularly reproductive and reproductive health related behavior of men and women. To specify, in the first section, findings are discussed by drawing on and linking to the theoretical literature on how social norms shape reproductive behavior and action. This is done along three major lines – initially, by holding study findings against the literature on the dynamic nature of social norms; then, by interrogating study findings in view of the evidence on the social determination of childbearing and fertility in sub-Saharan African societies; and lastly, by discussing findings within the frame of a gendered reproductive realm. In doing so, I reflect upon the consistencies, differences and contradictions between the extant literature and the study findings.

The second section builds upon the earlier section to locate and discuss study findings within the unique context of South Sudan – a context overwhelmingly defined by a state of chronic and ongoing insecurity and related uncertainty. Throughout, where applicable and as appropriate, implications for action are drawn for reproductive health policy and practice in South Sudan. Implications for action that are articulated in Chapters 4-8 are extended. Overarching conclusions of the study are articulated at the end of this section.

In the third section, I briefly reflect on the application of the conceptual framework in view of the research approach chosen, and I share some personal reflections on the research approach and the research process. I conclude with a brief discussion on the possible areas for further research, going forward.

**SOCIAL NORMS IN THE REPRODUCTIVE REALM: FINDINGS IN THE LIGHT OF THEORY AND OTHER EMPIRICAL WORK**

The overall research question of our study was: How do social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit? The findings presented in Chapters 4-8 illustrate the various ways in which society, its culture, its history, its community-level institutions, relational arrangements, operating together and independently, and often through linked social and gender norms, shape individual’s behaviours in the reproductive realm. While social norms shape the actions of individuals in a wide range of complex way, findings emphatically show that individuals, no matter how constrained they might be, do not passively subject themselves to these societal structural forces. Findings presented in Chapters 4-6 & 8 are testimony to how women and adolescent girls actively make sense of their circumstances and intentionally act to re-negotiate and subvert the structural constraints in their own interests, irrespective of the odds – the latter being stacked heavily against women in the insecure and unpredictable context of South Sudan. In the following sub-sections, the findings are discussed in light of the theory and other extant empirical work on social norms in the reproductive realm.
Multiple, competing norms

The findings of this study consistently (Chapters 4,5,6 & 8) show the presence of competing norms in the reproductive realm. For instance, Chapters 4 and 5 show that the societal norm that a couple should have as many children as possible, though entrenched, is under competitive pressure. It is under competitive pressure from the norm in Fertit society that one must take good care of children; and an emerging aspect of this norm is the recognition that this now entails and involves, unlike before, making financial provisions for the education of one's children – something that costs a lot of money in South Sudan. This together with the recognition that it is possible to bear the responsibility and the cost for providing good education to only few, and not many children, is putting pressure on the hitherto 'mainstream' social norm of having as many children as possible and is contributing to its reconfiguration. Chapters 4-6 show competing norms on matters related to pregnancy, childbearing and spacing of pregnancies. Findings also show that people invoked different, often mutually incompatible and even contradictory norms, for deciding on their actions, and to explain their actions.

These findings are consistent with Chowdhary & Mc Kague (2017) who have described various social norms in the reproductive realm in the Eastern Equatoria state of South Sudan. Mugo et al (2016, 2018) and El Musharraf et al’s (2017) work also shows the presence of multiple norms in the reproductive realm in South Sudan. Similarly, Dynes et al’s (2012) work from neighboring Ethiopia and Kenya, points to the presence of multiple social norms around contraceptive use. While Dynes et al (2012) do not discuss the competitive aspect of norms, they do report how their study subjects selectively referred to those social norms that were more in line with their beliefs and preferences. Our study extends this analysis to demonstrate the presence of multiple norms that sometimes contradict each other and exert competitive pressure on each other. Our study shows that people use these competing norms selectively depending on what their interest might be, and what might be possible in their society. These findings are consistent with Lockwood’s (1995) work on social norms in the reproductive realm. Lockwood (1995), drawing on empirical work from many parts of West and Sub-Saharan Africa, demonstrated that instead of singular overarching norms, each society has a 'range of normative notions that can be deployed selectively and strategically' by actors, either to maintain the status quo or to support change. He adds that behavior (people's actions) depends not only on social norms, but also on other notions and other imperatives of the practical kind. This is in line with the broader literature on social norms which posits that at any point in time, in a society, there are different social norms jostling for influence (see Bicchieri earlier).

Our findings confirm this in the context of South Sudan. Findings show that people do not simplistically act in reaction to structural forces or the normative powers of social norms, that people's interactions with each other and with the societal structures affects the very norms which they conceive as determining, guiding or regulating these interactions, and that in the process what constitutes the norm gets actively reconfigured. Findings reveal that in South Sudan many entrenched norms related to pregnancy, childbearing and spacing of pregnancies, are under pressure from competitive and contradictory norms; this implies that there is room
The current social conditions offer opportunities for health policy makers and public health programmers to intervene and to shape norm change towards social and health development. Findings suggest that the response needs to be multisectoral to address the many social determinants that constrain girls and women, and their reproductive health. Social policy interventions that facilitate girls and women’s education, economic interventions that enable women’s active participation in the economy, and political and broader societal interventions which pave the way for greater and meaningful participation of women in public life, are thus required. South Sudan’s development partners can contribute to this through supporting and enabling the operationalisation of the ambitious agenda articulated in South Sudan’s National Gender Policy (GOSS 2012).

Multiple norms - contrary invocations
The findings from this study show that not only is there no ‘one’ norm, often people turn to and selectively and strategically invoke and deploy particular norms. To specify, in Chapter 5, women, in defiance of the dominant norms, clandestinely used long acting contraceptives to delay and space pregnancies. To do so, they invoked the contrary social norm that a women’s body deserved to rest between pregnancies; women exercised further agency by deciding the duration of this rest themselves. Findings along these lines have also been reported from other parts of Africa. Mbekenga et al (2013) show how in Tanzania different norms are invoked by men and women while negotiating abstinence after childbirth. Giwa (2015) also found that in Nigeria amongst married couples, men and women invoked different social norms to negotiate family size and to space pregnancies. Similarly, as Chapter 7 shows, adolescent girls, much to the chagrin of adults who expected them to not get pregnant and to focus on school, mobilized the social norm that valorizes motherhood, to achieve two ends – to assure for themselves some social security through their child’s father, and to exit into the world of adults. Further, as Chapter 8 illustrates, some women did not use available services because they prioritized their dignity over everything else that was normatively expected of them by society – justifying this decision through a complex, perhaps convoluted invocation of competing norms. These findings are consistent with Bichierri (2006) understanding of the relation between social structure, social norms and social agents. They also reveal that while people’s actions are shaped by norms, actors in selectively mobilizing certain norms over other norms, exercise agency to shape social norms/social structure. Methodologically, these findings resonate with what scholars like Holy & Stuchlik (1983) recommend for those studying social norms – that accounts can help explain social norms, only if one explicitly remains aware of and accounts for the exceptions to the norm and to contrary invocations of norms by agency wielding individuals.

The complex sociality of reproductive actions: adjustment, agency, opportunism
A common feature across Chapters 4-6 & 8 was women and adolescent girls exercising agency. For example, as Chapter 4 illustrates, women exercised agency through the selective invocation of norms related to women’s right to rest their bodies, to space pregnancies. These findings
echo Johnson-Hanks (2007) findings from Cameroon. In her study on women's reproductive agency, Johnson-Hanks also found that women put “considerable conscious effort in organizing and administering their reproductive careers” (p 1039), often against great odds, by making choices and sequentially adjusting to unpredictable conditions. Also, in line with the findings from our study, Johnson-Hanks argues that in much of Africa, given the economic and social uncertainties, and given the social desirability of having many children, the choices that women make are not based on a long-term strategy centered around and assuming a single perpetual marital relationship. That instead women make decisions based on their judgments regarding if 'now is a propitious time to have a child with this man under these social circumstances'. Like findings from our study, Johnson-Hanks conclusion is that women, in making decisions of childbearing are very much exercising agency, but that “childbearing is very subject to the calculus of conscious choice without child numbers being part of the equation” (p 1038).

Similar observations have been made by Oppong (1995) in Ghana, Angin & Shorter (1998) in Turkey, and Giwa (2015 p99-127) in Nigeria. While on one hand these arguments resonate with our findings from Chapters 4 and 6, the findings in Chapter 5 and 8 show that in the study area, women's agency in the reproductive realm was severely constrained. Chapter 8 shows how some women in the study area did not use available maternal health services because they were afraid of their dignity being further violated. It illustrates the undermining of women's agency at the intersection of chronic insecurity, lack of economic opportunities generally, and unequal gender relations in Fertit society.

At another level, as Chapter 6 illustrates, many adolescent girls exercised agency through choosing to become mothers - using it as a means to adjust to, and exit the harsh circumstances they were in. The adolescent girls in our study thus leveraged the social norm that it was the responsibility of the child's father to care for and provide for the child and the mother. These findings in some ways relate to what Pradhan et al (2014) report in their systematic review of determinants of adolescent pregnancy in low and middle-income countries. According to Pradhan et al (2014), adolescent girls from lower economic backgrounds, and those with little access to income-generating activities, were more likely to become pregnant. However, unlike in our study where girls in some ways, and probably under peer influences, chose to become pregnant to exit their current social situations, the systematic review primarily refers to adolescent pregnancies occurring because of girls being married off early by their families. Our findings in some ways reflect what Cornwall (1996), and Giwa (2015) have found while studying gender relations in the reproductive realm amongst the Yorubas in Nigeria. Cornwall concluded that in matters of reproduction, children may not be the end in themselves; that through begetting a child, the mother and the father, together and/or independently, are forging relationships with other kin in the lineage of both, the mother and the father, and that these considerations are equally important. Cornwall argues that in many African patrilineal societies, through bearing children, the mother, in fulfilling the expectations of the man's family, can stake a claim to the social status and resources that accompany motherhood. Not unlike the Cameroonian women from Johnson-Hanks (2007) study, the adolescent girls in our study
also seemed to be engaging with the state of chronic uncertainty and unpredictability through an approach consistent with what Johnson-Hanks (2007) calls ‘judicious opportunism’.

Our findings imply that a monochromatic and victimhood-oriented representation of girls who become pregnant, is both inaccurate, and disrespectful of the agency these girls are often exercising. The young mothers who participated in this study overwhelmingly wanted to continue their education. These findings imply and emphasise the need for a more nuanced and empowerment-oriented approach to adolescent pregnancy. Taking an approach which engages with adolescent girls as rights-bearing actors with full agentic potential would enable policy makers and program managers to develop social and health policies and programs which create conditions for girls to imagine and achieve the futures they desire. In the immediate to medium term, actions to enable girls who become pregnant, to remain in school and/or to return to school, and to continue their education would be most useful. South Sudan’s development partners can contribute to this through supporting initiatives in this direction. In the longer term, South Sudan’s Ministry of General Education and Instruction, as it develops its 2018-2023 Strategic Plan, could focus on measures which systematically enable young mothers to continue schooling. South Sudan’s development partners are well placed to engage with the Ministry to ensure this. At another level, the reason why many adolescents in the study area wanted to become mothers, related to a social process whereby their peer group believed that bearing a child was the only way to escape their insecure and uncertain situation. Multisectoral interventions which work with young people, to provide viable professional and personal development alternatives, and which enable young people’s meaningful civic engagement in society were identified as the way forward for South Sudan’s youth in the recent ‘Juba Declaration on Youth Civic Engagement and Participation’ (UNESCO 2018). South Sudan’s development partners can contribute to the realisation of the agenda set out in this declaration by actively supporting the Ministry of Culture, Youth and Sports, the Ministry of General Education and Instruction, and UNESCO South Sudan, in operationalising this agenda. Such interventions would enable and support adolescent girls to make the life and reproductive choices they truly want – including, to become mothers, when they want to.

The gendered structure of the Fertit family unit

A key finding of our study is that the Fertit family is a consanguinially-based unit built around a core of brothers and sisters (blood relations) in the man’s lineage. The wife is seen as an outsider who has been brought, often bought (through paying bride price), into the family with the purpose of bearing children for the man’s family. Our findings also reveal that linked to these relational arrangements is the notion that the children the couple begets, belong to the man and his family, and that the children’s upkeep is the responsibility of the man and the man’s consanguinal family. This responsibility of upkeep and care extends to the children’s mother, but is tacit, and in some ways contingent on her ability to continue to bear children. Sudarkasa (1982, 1986, 1996), and Oyewumi (1998, 2011) have argued that this structure of the family and of social relations is a reality in many sub-Saharan African societies. They contend that
assuming the family as a conjugal unit consisting of a man, a woman and their biological children living and socializing as a family in perpetuity, as the ontologic starting point when studying social and family relations in such societies, is both inaccurate and problematic. Understanding the family as being consanguinely based, has helped this study to accurately depict and analyse the relational arrangements in the Fertit society, and to properly contextualize the inquiry and its findings.

This understanding of family and relational arrangements has implications for reproductive health policies and reproductive health promotion related programming amongst the Fertit, and broadly in South Sudan. These policies and strategies need to be revisited and revised in view of the social reality of the family being a consanguinal unit, rather than a conjugal unit. All reproductive decisions and actions are shaped by and occur within this social reality – to be effective, the reproductive health policy and practice, needs to reorient itself to this reality. For instance, health promotion activities should be targeted simultaneously at the reproductive woman and the members of her husband’s family; these activities should be complementary. At another level, the family structure means that women continue to be close to their siblings and remain an integral part of their father’s or brother’s family unit; social policy interventions for gender equality can leverage this relational arrangement and mobilise societal support by strategically invoking these relationships.

**The social determination of childbearing and fertility**

As Chapters 4-7 show, consistent with Caldwell’s contention, the overarching emphasis in Fertit society was on ancestry, descent and family lineage. The social norm around marriage was that one married a woman to be able to bear children, to replace the older dead family members of one’s (the man’s) family. These findings thus attest to Caldwell’s thesis. On a different level, Chapters 4 & 5 show that women desired to have many children because the man’s family expected them to, and more immediately, having children was seen as a way to maintain their value in the eyes of the man and his family, thus ensuring their continued relevance and ‘worthiness’. This was, albeit in a different way, the case for adolescent girls too; they saw motherhood as a way into the world of adults and as a way to access the privileges of being the mother of someone’s child.

Caldwell’s thesis however does not fit some of the explanations of reproductive actions and choices of people in the study area. In our study, childbearing had little to do with the relationship between the mother and the child, or with the hope of extra hands for the mother, or with the idea of insurance in old age, but rather it had to do with maintenance of the relationship between the woman and the husband’s family. Women in our study did not have a labor resource or old age insurance oriented future looking view in having children. Their goals were more immediate, opportunistic, tactical, and often a means to avoid problems, or as was the case for adolescent girls, to exit undesired social situations. After all, in the study area it was a common understanding that children belonged to the man and his family lineage – women could hope but could not have any assurance that they could stake a claim on the children. Similar instances of divergence from Caldwell’s ‘wealth flow’ thesis have been reported by others. Thornton &
Ficke (1987), and McDonald (1993) demonstrate the inapplicability of the thesis in China, South Asia, and East Asia. Mason (1992) has illustrated how the thesis, and other theories of fertility vary across cultures. Our findings also show the complex sociality of women’s and adolescent girls’ reproductive actions and behaviours. While no similar empirical work was found in the literature, as discussed in earlier sections, these findings in some ways mirror what Cornwall (1996) has reported from Nigeria, and what Johnson-Hanks (2007) found in Cameroon. Our findings illustrate how the logics underpinning reproductive actions and choices are unique for each society. The implication of these findings is that global health development partners, and population and health policy makers and programmers, need to explicitly seek to understand the unique logics underpinning reproductive actions and choices, for each society, and to tailor their intervention approaches accordingly. In the diverse and multicultural context of South Sudan this means that studies like the one presented here, need to be implemented in different parts of the country and among different communities. For instance, within the erstwhile Western Bahr el Ghazal State itself, there are two other major communities, the Baggara-Arab people around Raga town, and the Jur-Chol people around Mepel and Aweil towns; both communities have unique social and gender norms around family structure, reproduction, and reproductive health. Gaining systematic insights into these social relations and norms would enable the provision of culturally appropriate and responsive health and reproductive health services in these areas. Researchers, from South Sudan and from other parts of the world, can collaborate and work together with the Government of South Sudan and its development partners to take this knowledge agenda forward.

Patriarchy and masculine hegemony in flux

Our study findings also exposed the hidden and vulnerable underbelly of masculinity, male privilege and patriarchy in the local Fertit society. Findings show how everyday social situations are shaping social practices such that the entrenched gender relations are being disrupted and can no longer be enacted, and thus reproduced and maintained, in the society. For example, as illustrated in Chapters 2 and 7, the lack of work and employment opportunities for men, and their inability to provide for their women and children has weakened men’s domination in all social arenas, particularly in the domestic and reproductive arenas. Since many men, particularly younger men, can no longer fulfil the traditional responsibility assignments and fail to provide for their families, the privileges that accompanied these responsibility assignments are being subverted. Men are unable to automatically claim what has traditionally been patriarchal privilege – society thus now takes a more accommodating view of women taking over responsibilities (and by extension decision-making powers) in the domestic and to some extent, reproductive realms. These mechanisms have been triggered by internal displacement and linked disruptions of the social fabric; displacement has meant that men are often simply absent, and not around to fulfil their provision and protection (security and social protection alike) related responsibilities. These failures have also undermined men’s positions of advantage in social relations.
While these shifts in gender power relations cannot by any means be considered definite or permanent, our findings suggest that some traditional leaders (the Sultans) may be open to and perhaps even supportive of a reconfiguration of traditional relations in Fertit society. Findings also suggest that this viewpoint may not merely be a pragmatic response to the social situation, but that the Sultans might in fact be motivated also by social justice and ethics concerns, and a recognition of changing times. Further, many men in the study community seemed to accept the changes that are afoot in Fertit society. Some men seem to go further; they recognise the need for, the importance, and to some extent, the overall benefits of more equal gender relations in society.

These findings are in line with Lockwood (1997) who has argued that in much of sub-Saharan Africa, reproductive relations are intertwined with gender relations and with relations in the productive household and agricultural realms. Drawing on historical analysis, he contends that these relations are of interdependence and reciprocity; they have historically been maintained in a state of tenuous balance between the productive and reproductive domains. Whenever relations in the productive realm come under stress, and harmony is undermined, there are repercussions for the conduct of reproductive and sexual relations. He goes on to argue that in most societies of sub-Saharan Africa, sex forms a link between the two realms, with conjugal sexual relations being ‘embedded in a transactional nexus that is strongly affected by the relative material positions of men and women’. He cites historical instances to explain that when mutually recognized and interdependent ways of gendered cooperation in production broke down under pressure (e.g. during colonial times, and transformations in agriculture and trade), relations of harmony and interdependence in the reproductive realm were also undermined – almost always at the expense of women’s well-being and health.

Our study findings thus point to the broader socio-politico-economic determination of social relations and reproductive and health seeking behaviors. The implication for health and development policy makers and practitioners is that even if post-conflict reconstruction and recovery is an immediate priority for South Sudan, efforts need to be simultaneously directed towards all round social and economic development; only then can men and women achieve equal and healthy social relations and good (reproductive) health. Our findings also suggest that paradoxically, and perhaps serendipitously, the conditions in South Sudan might be ripe for a recalibration of social and gender relations to occur, as discussed in Chapters 4-7. In the medium term there is room for cautious policy intervention to nudge this social change. For instance, given that there is some openness to joint decision-making on reproductive matters, interventions which promote dialogue among couples, and among the man’s family members, could be a feasible and effective way forward. Similarly, explicit social policy interventions which target men, and promote dialogue in society about masculinities and patriarchy, can pave the way for a re-apportionment of responsibilities in the reproductive realm and beyond. And as argued in Chapter 7, to get men to see social change as being positive and also in their emancipatory interests; findings in Chapter 7 suggest that peer-group based approaches might be particularly appropriate for intervening with men in the study area. In the long-term, broader and more comprehensive gender transformative social policy interventions are required.
INSECURITY AND THE REPRODUCTIVE REALM

Findings in Chapters 4-8 demonstrate how the insecure, unstable and uncertain context of South Sudan shaped the actions of individual in a wide range of complex way. The situation in South Sudan is characterized by low-intensity, sporadic and chronic conflict characterized by insecurity, uncertainty and fear (Hutton 2014, Pendle 2014, Noel & De Waal 2014). Evidence from South Sudan shows that this chronic and ongoing insecurity has led to physical destruction of health and social infrastructures, neglect of long-term and strategic public policies and planning, internal displacement of populations and disruption of societal institutions (Hutton 2014, Pendle 2014, Noel & De Waal 2014). Findings in Chapters 4-8 demonstrate how the disruptive influence of insecurity pervades all social realms; they show how the insecurity, uncertainty and fear has shaped men and women's actions and behaviours in the reproductive realm. In this section findings are discussed in light of the theory and extant empirical work on how conflict, insecurity and uncertainty shapes actions and behaviours in the reproductive realm.

Women and the burden of conflict and insecurity

Chronic conflict and insecurity continue to affect the study area and South Sudan generally. During the stays in Wau, the daily security updates based on inputs from the United Nations Mission in South Sudan, indicated that there were regular incidents of violence in and around Wau. Furthermore, a curfew was always in place, and one could not venture outdoors after 6 pm. Similarly, when venturing out for field trips to the rural area, there were strict instructions to return to the secure compound in Wau, by 6 pm. It was also mandatory to seek security clearances from local government offices, and to carry satellite phones for emergency communications. These warnings and codes of conduct were strictly imposed and were reiterated by our locally based collaborators too. Chapter 8 engages extensively with how the insecure environment instilled fear in women's minds, and how it affected their health care seeking decisions. Chapter 8 exposes how insecurity and instability amplifies vulnerabilities, further marginalizes the weak, and disproportionately affects women. Urdal & Che (2013), in their recent and comprehensive review, have examined empirical evidence on the social effects of conflict. They also found that found that in such situations the patriarchal roles i.e. men's roles as protectors of women, children, and the country, are reinforced, and women's roles as subordinates requiring protection, are reaffirmed, and thus further entrenched. Our findings are in line with their conclusions – women, children, the elderly, and the mentally ill, are the most vulnerable and worst affected, and that women are particularly vulnerable. Our findings are also consistent with Ityavyar & Ogba (1989) and Ghobarah et al's (2004) reviews on the effect of conflict on society and public health.

In our study, perhaps the most telling evidence of the pervasive and insidious influence of the chronic insecurity and uncertainty can be seen in the adolescent girls’ explanations of their pregnancies. Their argument that since one can die any time, it is better to “have a child who will call you 'mama'”, signals how uncertain life is in the study area. These findings (Chapter 6) point to the corrosive influence of chronic disruption and insecurity; they exemplify
how the chronic insecurity has led to adolescents not being able to imagine a future without the threat of premature death. At another level, findings in Chapter 4 & 5 show how conflict driven displacement meant that many men in the study community were either missing or were away, and thus unavailable to provide for their families. Chapter 7 presents a different side of this disruption. It shows how the economic disruption has led to a situation whereby many men in the study area do not have the means to make and support a family and are thus unable to uphold their responsibilities. These findings are in line with the conclusions of Rabrenovic & Roskos (2001), and Rehn & Sirleaf (2002); these authors have argued that in contexts with low grade and ongoing conflicts, women are often left to manage households on their own, in the face of poor access to resources, disruptions of services, and the loss of men’s contribution to the households. Our findings however reveal a far more complex and a much more problematic aspect to this phenomenon of men retreating from their responsibilities. Chapters 4, 5 and 8 show that some women in the study area view their pregnancy, and their unborn child, as being the responsibility of the man. And if the man does not fulfil this responsibility, these women are wont to be apathetic towards their pregnancies – to the detriment of their own and their unborn child’s health, albeit unwittingly. That said, as discussed in detail in Chapter 7, these absences are also opening opportunities for women to step in and take over responsibilities in the productive realm, and to access the privileges that follow, in the reproductive realm, and more generally.

The chronic conflict and the ongoing insecurity, and its consequences, in many ways permeated all aspects of society and social life in the study area – this was so at the time of the study, and most probably remains true today. Jacobson (2007) argues that the multifaceted and relentless disruption occurring due to chronic conflict and insecurity, does greatest damage to those who are the weakest and most disadvantaged. Consistent with his view, and as illustrated in Chapter 8, our study found that the most vulnerable women were being worn down by the constant micro insults and violations of their social dignity. Jacobson (2007) adds that this may be so much so that they isolate themselves and avoid social interactions as much as possible – manifesting empirically, in the worst scenario as a reluctance to seek help or access resources, passivity or ‘learned helplessness’. This was the case for many in the study area. Chapter 8 reveals how the fear that one’s dignity might be violated in a particularly social interaction can lead one to avoid that interaction, irrespective of how important or potentially beneficial that interaction might be.

The broad implication of these findings for South Sudan’s international health development partners is that in addition to supporting essential health services, they must in parallel, actively advocate for and support efforts to restore peace and stability in South Sudan. Our findings underline the importance of renewing international efforts to restore peace and stability in South Sudan – unless this comes to be, the weakest and the most disadvantaged, will continue to suffer. Our findings also imply that till security is established, public health programmers and international health development partners need to tailor service delivery, particularly reproductive health service delivery, to these circumstances. For example, where necessary and possible, to take services closer to people, instead of expecting them to traverse insecure spaces to access services. Health and social services and the NGOS providing health services need to
collaborate to consciously identify the most vulnerable women in society, and to support them to access health services without fear. In the medium to longer term, South Sudan’s development partners can contribute to this through supporting and enabling the operationalisation of two of the seven core values articulated in South Sudan’s National Health Policy 2016-2015, i.e. “Dignity and respect for all individuals seeking health care services shall be guaranteed.” and “Health is a human right; equitable access to health services shall be pursued.” (MOH 2015 p 11). In South Sudan, NGOs provide the bulk of health services; they do so collaboratively with the national, state and county level health departments. The ‘Health Cluster’ is the forum for coordination between NGOs, government and the international funders; the ‘Health Cluster’ is well placed to support and resource an action plan for embedment of dignity considerations in all aspects of health service provision. As mentioned in Chapter 8, a first step in this direction could entail the development of a locally appropriate tool to enable service users and practitioners to jointly identify what constitutes dignified services for different service users, and how best it could be achieved.

CONCLUSIONS

Social norms have a strong influence on the reproductive and reproductive health related choices and actions of people. While their influence is powerful, it is contingent upon the context broadly and the unique context of the individual or group the norm operates on. Our findings show this contingent nature to be rooted in the social and negotiated construction of social norms, and allow the conclusion that social norms are mutable, and amenable to change.

Our findings show that social norms are conduits for the expression of structural forces; they help maintain and reproduce societal structures and relational arrangements – in the reproductive realm, largely to the disadvantage of women. These findings lead us to conclude that public policy interventions are necessary to change the unequal gender relations in the study community. Findings also signal that this needs to be done with caution, through engaging actively with men and men’s family members, using approaches which enable men to view social change as being in their “emancipatory interests”.

The long war has weakened or disrupted the existing social norms in South Sudan, and existing social norms on reproduction, childbearing and family size are under competitive pressure. The return of peace and stability will create opportunities for men and women to challenge and reconfigure these social norms. It would be an opportune time for reproductive health policy makers and program managers to work with people’s aspirations for freedom and a better life and use the insights about existing and emerging social norms on spacing and caring for children in their health promotion activities.

Conflict, insecurity, and instability have an all-pervasive disruptive influence on all social realms, including the reproductive realm. Peace, security and stability are the most important determinants of health and reproductive wellbeing. If the recent (August 2018) peace agreement between the warring parties in South Sudan holds, many of the problems discussed in this thesis can be solved, and much of the insights gained here can be used to inform concrete actions to
improve the responsiveness of reproductive health policies and program in the study area, and South Sudan at large.

**REFLECTION ON THE RESEARCH APPROACH**

**Reflection on the conceptual framework**

Findings in Chapters 4-8 testify that De Francisco et al’s (2007) framework worked well as a tool to guide our inquiry – that it allowed a thorough examination of the reproductive decisions and actions of women and men. While the framework enabled a comprehensive exploration of how social norms shape actor’s behaviours in the reproductive realm, it also lent itself well to applying the critical realist research approach and the African feminist theoretical perspective to the inquiry. To specify, throughout Chapters 4-9, the analysis demonstrates and emphasizes the dynamic and bidirectional interaction between the wider structural environment – referring to the concentric outer layers of De Francisco et al’s framework, and agency, referring to the innermost layer within which intentional human action occurs.

The choice of the realist approach and an African feminist theoretical perspective has also enhanced the explanatory yield of our inquiry. It enabled the identification and appreciation of how broader social, political, and economic influences intersected to constrain women’s and men’s agency. At the same time, it enabled the inquiry to explicitly look for and to recognise women’s (and girls) intentionality and agency in the face of much adversity (as is the case in the context of South Sudan). As indicated in Chapter 2, this was possible because the choice of the research approach required one to actively engage with the premise “that agents do not react to structural forces alone, but rather that they actively interpret their own structural context, attaching unique meanings to their (and other similar actor’s) situations and that agents constantly and intentionally try to re-negotiate the structural constraints in their own interests – and in the process constantly reconfigure the very structural environment that shapes their actions” (p26).

The chosen research approach thus allowed the inquiry to overcome the problems that Lockwood (1995) has warned of – that when researching the normative antecedents of human behaviour, taking a structural-functional epistemic position whereby actors’ actions are deemed to be governed by norms that are in turn driven by social structure, is problematic. Lockwood’s warning draws on Holy & Stuchlik (1983) who in their seminal work on social norms have argued that,

instead of focusing analytical attention on the problem of whether an action is norm conforming or norm-breaking … attention should be focused on which norms, ideas and reasons were invoked by the actors for the performance of the action [p 110].

Applying such an analytical approach and paying explicit attention to both norm confirmation and defiance, and to norm diversity, competition, evolution and change, has enhanced and enriched the yield in this research.
Reflections on the research approach and my involvement in the research process

Limits to knowing and knowability

I started the study with the view to gain insight into the local social norms shaping reproductive decisions and actions of the people of Western Bahr el Ghazal. I became aware that while knowing what is going on and what people are doing was important, it was more meaningful if it was accompanied by insights into why things were the way they were. During the research process I also recognised that there were multiple possible explanations for why things were the way they were, and that there was no one complete explanation. Finally, reading through literature it became increasingly clear that the explanations I arrived at were limited. I realised the impossibility of one being able to conceptually access and grasp the relevant aspects of the social world, let alone all of them, and certainly not in one research effort. One clear example relates to Chapter 7 which presents an account of an important cross-cutting theme that became apparent only during the analysis of the data. Since the study was not set up to explicitly explore responsibility assignments in the reproductive realm, what is presented in Chapter 7 is limited to what we happened to learn – saturation has thus not been achieved and many important facets remain to be explored and analyzed. Similarly, more broadly, what was gleaned from the data was constrained by the theoretical tin-openers that I used to unpack the data; inevitably, many facets of the phenomenon under study remain unrevealed.

Dealing with interpretations

Since the concept of ‘norm’ and ‘normative’ behaviour and action had primarily been studied in sociologists, I found it appropriate to draw on theoretical insights from the social sciences, primarily, sociology, to frame my understanding of the research questions, and the analytical approach. I thus also drew upon methods used in these disciplines. Broadly, two main methods for investigating norms have been proposed: observation of behaviour, and collection of verbal statements by actors. I recognised that both approaches had their limitations. I realised that for both, one is dealing with interpretations – both with actors’ interpretations, and the researchers’ interpretations.

Regarding researchers’ interpretations, the process starts with the framing of the question itself. Even at the point of writing the grant application for the SHARP project, I was acutely aware of the constraints to me being able to understand the needs of the potential beneficiaries of the project. This awareness became more accentuated during the process of developing the research proposal. Which questions deserved answers? What were the ways of knowing? Who all could be the knowers? How could one reconcile these questions of ontology and epistemology to the practicalities of implementing a study within finite time and resources? In many ways, the time constraints placed by the project period forced me to engage with these questions in time. I realised that all social researchers must somehow start out with some a priori analytical basis and concepts for framing the research questions, and research approach. I learnt from Holy & Stuchlik (1983 p33) that this was inevitable and on its own, not a problem; problem only arises when qualitative researchers do not recognise the provisional nature of these a priori ideas and concepts and become unwilling to abandon a priori definitions and ideas.
At another level, I felt that accepting the said word of those being interviewed, as ‘the’ reality, as many positivist social scientists on one hand, and many constructivists on the other, are wont to, would yield not only superficial, but also incomplete accounts. Again, Holy & Stuchlik (1983) helped me appreciate that since norms are social, negotiated and often dynamic entities, researchers must not simply substitute their own and a priori ideas and notions for those of the people they are studying. They recommended that studying norms and normative action requires active sense making at the interface of social theories, the said word of those being studied, the context, and the researchers understanding. Toury’s (1995) argument that normative pronouncements of actors should be best studied as a reflection of the cultural constellation in which they were produced, further helped me to put the different interpretations proffered by different respondents, in perspective.

**Epistemic privilege**

While engaging and dealing with interpretations – both with actors’ interpretations, and the researchers’ interpretations – I realised that as the researcher, I had a position of privilege. And that I was the de facto gatekeeper of what would ultimately be presented, not least because of the word limits of journals, my own articulatory limitations, and the compromises I would make with my co-authors. These reflections about my privileged position as the knower in this enterprise, led me to read extensively about and mull over the power dynamics and politics entailed in the production of what passes as credible, publication worthy and scientific knowledge. While all reflections are beyond the scope of this section, one strand cannot be excluded. As a post-colonial subject myself, and having seen at close quarters, and having endlessly criticized the erstwhile colonial powers’ continued and entitled claims of epistemic superiority, both overt and covert – I found the process of conducting this study a very revealing, sometimes disconcerting, but ultimately, a very important learning exercise. At different points in this study I was in different shoes. I found myself in the shoes of the privileged researcher from a developed, wealthy, white land and institution, participating in and reproducing the very claims of epistemic superiority that I had all along criticized. And as a quirk of fate, as part of the study process I also found myself at the receiving end of this power equation. These reflective moments were confusing, sometimes tense and awkward, yet ultimately personally revealing and enriching. For example, these reflections led me to read the works of and learn from African feminists like Niara Sudarkasa, Oyèrónké Oyewûmí, Ifi Amadiume, Desiree Lewis, post-colonial social theorists like Homi Bhabha (1994) and indigenous standpoint theorists like Foley (2003). These works, particularly those of Sudarkasa and Oyewumi were not only very useful to help make sense of the study findings, the literature I discovered and read in the process, has helped me better understand myself as a researcher and hopefully as a person.

**Arriving at and recognizing my epistemic stance**

These readings and experiences helped me clarify and arrive at my epistemic position vis-à-vis this study (a critical realist ontology and epistemology), but also more broadly as an international
DISCUSSION AND CONCLUSIONS

researcher. I approached the study with a view that norms were real, and that this reality was independent of whether we could know about it or what we could know about it. I approached the study with the view that one can only capture a small part of a deeper and vaster reality, and that all knowledge is merely an approximation of the reality. While conducting the study, I also realised and thus read about the limitations of a critical realist stance. I found the feminist critique of critical realism, particularly compelling, and relevant to making sense of the emerging findings – I have drawn upon these readings throughout this study.

AN AGENDA FOR FUTURE RESEARCH

The insight gained through this research sets the stage for a wide variety of inquiries, of both conceptual and applied nature, across many disciplinary domains. This section briefly presents a few lines of inquiry, specifically those that emerge immediately from or extend the findings presented in Chapters 4-8 and discussed earlier in this chapter.

A key theme across Chapters 4-7 concerns the nature, structure and relational arrangements within the Fertit family. Throughout this research, this theme has been understood within a theoretical frame that these arrangements are socially constructed, negotiated and mutable – this research confirms this theoretical claim. This research points to some of the changes in the environment, particularly those brought on by conflict and uncertainty, and presents some examples of how agents are both exploiting and navigating these environmental changes to reconfigure the relational arrangements within the Fertit family. As South Sudan extricates itself from conflict, and as the overwhelming structural influence of conflict and uncertainty recedes, structural forces hitherto in the background, will come to the fore; these will once again exert influence to reshape the nature, structure and relational arrangements within the Fertit family. Research which draws together theoretical insights and insights from empirical work from settings which have experienced similar transitions, will be very valuable from a policy perspective, including but not limited to reproductive health policy.

Along similar lines, a key theme across Chapters 4-8 concerns patriarchy and male privilege, and its consequences for women’s reproductive health amongst the Ferit. Findings show how the entrenched gender order is under stress. While this situation is presented as an opportunity for public policy intervention to reconfigure the unequal gender order, the complexity of the situation and the risks of simplistic problematization of men’s roles in the reproductive realm are also highlighted. An argument is made for public policy interventions to take a cautious and informed approach. The caution relates very much to the major knowledge gaps around the construction and dynamics of masculinity and patriarchy in the Fertit society; the need for in-depth research on this subject is critical (to inform public policy) given the violent history of the country.

At another level, but still related to the nature, structure and relational arrangements within the Fertit family, are applied research questions about what a ‘consanguinely’ based family structure implies for how population health policies and reproductive health programs are oriented, organised, and implemented in South Sudan and to other similar societies in Africa.
Questions around who wields the most influence in reproductive decisions and how best to leverage this influence in a way that enhances gender equality and social well-being, require further research. This research suggests that these questions need to be answered uniquely for adolescents, young adults, and older adults, as circumstances and needs are different at different stages of life, and population health policies and reproductive health programs need to meet these unique needs.

Chapter 7 sets the stage for both conceptual and applied research of immediate relevance. That many women prioritized their dignity over everything else, including matters sacrosanct i.e. the health of the unborn child, raises many questions around the psychological and social processes through which such decisions are made in times of stress and duress. Women’s fears of their dignity being violated also requires explorations into the locally appropriate ways and means to both allay these fears, and to reconfigure health service provision, including through inter-sectoral collaborative action.

In as much as the works of African feminists and ideas of post-colonial social theorists (Bhabha 1994) have shaped this research, I am acutely aware of the constraints that my epistemic position places on what I could find, what I found but could not see, what I could see but did not understand, understood but did not deem sufficiently important to include, or simply could not articulate. My readings on indigenous epistemologies, and reflections on the process of this research, lead me to believe that having local co-investigators, and participation of knowledgeable community members in the research team, while very valuable, is not enough to grasp the lived realities of people. From a research point of view, there is room for and a need to conduct inquiries that are true to the ‘Indigenous Standpoint Theory’ (Foley 2003). This study sets the stage for and prepares me as a researcher to be part of such a research project, going forward.
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South Sudan is a large, multi-ethnic, multi-religious, multi-cultural nation of 12.32 million people. South Sudan has one of the highest burdens of ill health in the world. Decades of war and conflict have destroyed much of public services, including health services. South Sudan performs poorly on all health and development indicators; the reproductive health situation is particularly dire. On key reproductive health indicators like maternal mortality, adolescent pregnancy, family planning use, and institutional delivery, South Sudan is one of the world's worst performers. Women and adolescent girls disproportionately bear this burden of reproductive ill health. With support from international development partners, South Sudan is in the process of restoring peace, and rebuilding its public services and health system – infrastructure is being strengthened, human resources for health are being developed, financing and supply systems are being put in place, and governance mechanisms are being instituted.

Evidence shows that social and gender norms in a society shape the understanding about what constitutes health, appropriate health related and care seeking behaviour, and what men and women could and should do. A nuanced understanding of these social norms and relations is critical for tailoring health services and policies to the unique context of each society. This study sought to gain this insight in relation to reproductive health amongst the Fertit people of Western Bahr el Ghazal (WBeG) state of South Sudan. It sought to answer the research question: How do social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit people? Women's and adolescent girls' reproductive choices and actions were explored and analysed through examining them in the context of social and gender identities and relations in Fertit society, and by interrogating these social relations in view of the broader social, cultural, political and economic environment. The focus throughout was on understanding why things were the way they were, and why people, particularly women and adolescent girls, did what they did.

With a view to explore the research question in-depth, study questions focused on exploring women's and adolescent girls' decisions around childbearing and spacing of pregnancies; on women's decisions around care seeking; and, on what the articulation of men's role in these processes meant and connoted. Choosing these foci allowed the inquiry to dig deeply into and to reveal the many complex and dynamic ways in which social norms influenced reproductive and healthcare related behaviours. The research was implemented in Wau County of Western Bahr el Ghazal state of South Sudan. Semi-structured interviews and focus group discussions were conducted with purposively selected participants, including community members (adults and adolescent girls), health workers (clinical officers, nurses, health assistants, community health workers) and key informants (traditional leaders, traditional birth attendants, state and county level SRH service managers, and NGO representatives). Data was collected over a 2-year period from June 2014 to November 2015.

Cialdini's conceptualisation that social norms are one's beliefs about what others do and of what others approve and disapprove of, is used in this study. Norms are informal rules of behaviour that dictate what is acceptable within a given social context, and people comply with social norms in anticipation of social approval for compliance or sanctions on noncompliance. The enforcement and maintenance of these informal rules of behaviour occurs through
a combination of peer/group processes and broader social influences. Guided by De Francisco et al.'s framework of 'Circles of Influence Affecting Sexual and Reproductive Decisions,' an interdisciplinary, critical realist approach was taken to conduct the inquiry. This entailed paying explicit attention to the context of social organization and social norms by which specific societies condone or condemn certain reproductive behaviors, and thereby shape decisions and actions of the reproductive couple. The inquiry was informed by the recognition that these contexts of social organization, social relations and social norms, operating through culture, religion, and politics, in conjunction with economic influences, normatively shape the reproductive decisions and actions, of individuals and of the reproductive couple. The inquiry was also informed by the recognition that reproductive options are limited and constrained by the social institutions and relations individuals inhabit; and that in each society, these social institutions and relations are embedded in local, historical and yet dynamic patterns of social organization in the form of the family, community, kinship and other social relations. The inquiry was guided by the notion that individuals are not merely passive subjects of social norms, but rather are active agents, actively and constantly trying to re-negotiate the structural-institutional constraints in their own interest – and in the process constantly redefining the very structural-societal institutions and norms that shape their actions. The focus of the inquiry was on unpacking 'how' social norms shape the reproductive and related healthcare seeking decisions and actions amongst the Fertit. To do so, various theoretical insights from different social science disciplines were used. Doing so, helped shed light on and put in perspective, the different facets of the phenomenon under study. As they emerged, findings were shared with key stakeholders in Western Bahr el Ghazal state and at the national level. Findings have been published in international peer reviewed journals; they are included as chapters 4-8 here and are summarized below.

An overarching and key finding of this study is that the Fertit family is a consanguinally-based unit built around a core of brothers and sisters (blood relations) in the man's lineage. The wife is seen as an outsider who has been brought, often bought (through paying bride price), into the family with the purpose of bearing children for the man's family. Findings reveal that linked to these relational arrangements is the notion that the children the couple begets, belong to the man and his family, and that the children's upkeep is the responsibility of the man and the man's consanguinal family. This responsibility of upkeep and care extends to the children's mother, but is tacit, and in some ways contingent on her ability to continue to bear children. It emerged that the consanguinal nature of the Fertit family unit shapes all actions in the reproductive realm and many a reproductive health related decision-making process in Fertit society. Understanding the family as being consanguinally based, and not as conjugal unit (where the man and woman come together to start a family), has helped this study to accurately depict and analyse the relational arrangements in the Fertit society, and to properly contextualize the overall inquiry and its findings.

In Chapter 4, the social norms shaping decisions about family planning among the Fertit people are presented. Overall, the chapter shows that social norms have a strong influence on the reproductive health related choices and actions of people. Findings reveal that in the study area, women have little choice but to meet the childbearing demands of husbands and their
families (the consanguinal family). Findings show that among the Fertit people, the social norm which expects women to have as many children as possible remains well established. Findings also show how this norm is under competitive pressure from the existing norm which makes spacing of pregnancies socially desirable. We found that young Fertit women are increasingly, either covertly or overtly, making family planning decisions themselves; with resistance from some menfolk, but also support from others. We further found that the social norm of having as many children as possible is also under competitive pressure from the emerging norm that equates taking good care of one's children with providing them with a good education.

The findings in chapter 4 signal that the return of peace and stability in South Sudan, and people's aspirations for freedom and a better life, is creating opportunities for men and women to challenge and subvert existing social norms, including those affecting reproductive health, for the better. The key message from the findings in chapter 4 is that social norms are dynamic and subject to change. And that sexual and reproductive health programmes in WBeG should work with and leverage existing and emerging social norms on child spacing in their health promotion activities.

Chapter 5 presents an analysis of how gender norms and gendered social relations among the Fertit people affect women's ability to exercise control over their reproductive lives, and thereby their sexual and reproductive health. Overall, the chapter shows that women across all age groups have little choice but to meet the childbearing demands of husbands and their families. That they are frustrated about how men and society are letting them down, and how they are left to bear the reproductive burden alone. Findings also show how men are also constrained. The study exposes how the context of poverty and chronic insecurity in South Sudan offers few opportunities for pride and achievement for many men. It reveals how for many men, complicity with hegemonic practices entailing unequal and unfair gender norms, is a way to belong and feel secure in their masculinities - often at the expense of women's reproductive health. Chapter 5 reveals how inequalities in the domestic, social and economic spheres intersect to create social situations wherein Fertit women's, and to some extent men's, agency in the reproductive realm is constrained. It is argued that as long as economic and social opportunities for women remain restricted, and as long as insecurity and uncertainty remain, many women will have little choice but to resort to having many children to safeguard their fragile present and future. That, unless structural measures are taken to address these inequalities, there is a risk of widening of existing health inequalities and of emergence of new inequalities.

In South Sudan, by the age of 19, one in three girls is already a mother. While Chapter 6 recognises the risks of adolescent pregnancy, it examines the issue from the adolescent girl's perspective. It presents a critical account of adolescent South Sudanese girl's reasons and explanations of childbearing. It discusses their experiences and views on childbearing and attempts to explain their reproductive choices and actions, and reveals how for many adolescent girls, having a child had multiple meanings. It represented an attainment in a context where prospects of achieving something socially valuable through other means, are very few. It symbolised social worthiness. It served as a 'ticket' into the world of adults – allowing girls to exit from households where they are often dependent, unwelcome and/or in penury, to
make their own homes, and to enter the world of respectability. Chapter 6 emphatically shows that conflict, insecurity, and instability have an all-pervasive disruptive influence on all social realms, including the reproductive realm. It shows how the insecurity and uncertainty limits the economic and social opportunities for young women, and how this leaves many with little choice but to resort to bearing children to safeguard their fragile present and future. The key message is that instead of simplistically problematizing adolescent pregnancy in South Sudan, it is important to take into account the experiences and standpoints of adolescent girls, and to recognise that in choosing to become mothers, they are in many ways exercising agency despite being severely constrained by complex, insecure and unfair social circumstances. A case is made for taking a more nuanced view of adolescent pregnancy in South Sudan at public policy and program levels; it is argued that such an approach will allow the development of more appropriate, realistic and inclusive reproductive health and social policies and programs.

Chapter 7 presents an analysis of a major theme in our findings – a narrative around reproductive responsibility, its assignments, its upholdment and its abrogation, by men in Fertit society. This chapter critically examines and reflects upon this narrative of men being held responsible for decisions, indecisions, and the related problems in the reproductive realm; and also, how, men, women, and society, normatively assign men the responsibility for solving these problems. It exposes the social inequalities and entrenched gendered privileges that these assignments of responsibilities in the reproductive realm, connote. Chapter 7 unpacks the social practices of assignment and apportionment of responsibilities in the reproductive realm to expose the unfair nature of social and gender relations. It exposes how gender norms are stacked against women and signposts the health and reproductive health related implications. It is argued that the ongoing social disruption in South Sudan offers a unique opportunity for intervening to renegotiate and re-establish a more equitable social compact. A case is made for public health policies to prioritize social interventions which challenge patriarchal privilege without simplistically problematizing men's roles and actions in the reproductive realm. The chapter contends that interventions at the societal level are necessary to trigger change in the unequal gender relations. Drawing on theory and empirical evidence, it is argued that this needs to be done with caution, through engaging actively with men and men's family members, and through using approaches which enable men to view social change as being in their 'emancipatory interests'.

In the study community, and in South Sudan at large, many women face geographical, financial, security and cultural barriers to the use of reproductive health services. While recognizing the importance of these barriers, Chapter 8 focuses on the 'social accessibility' related barriers. This is done so to highlight the importance of this usually neglected dimension of accessibility; in the process, a contribution is also made to extend our understanding of what all the notion of 'social accessibility' could entail. Findings in Chapter 8 reveal that women's decisions to use available health services were not merely about whether they were aware of risks involved in pregnancy and childbirth, or about whether the services were reachable, affordable or of good quality. We found that in the study community the social norm is that a pregnant woman is expected to be well taken care of and should be seen to be well taken
The appearance of being well taken care of, socially dignifies the woman's pregnancy. In view of this, a woman's decision to seek care during pregnancy and childbirth also depended upon whether in the process of stepping out of her home to go and use services, her dignity as a pregnant woman could be maintained and protected – from the judging eyes of society, other women in the health facility, and while interacting with health workers. Findings presented in Chapter 8 reveal that a woman's decision to use available services was the result of a complex trade-off she was willing to make between the benefits she thought the care would bring to her, and the potential risks to her social dignity. Chapter 8 also exposes how insecurity and instability disproportionately affect the most vulnerable women. It spotlights that those who are most disadvantaged and vulnerable, may be so worn down by the constant and myriad violations of their social dignity, that they may isolate themselves and may become reluctant to seek help or use services, even when these are available. A case is made for health services to recognise the issue and to meaningfully respond by addressing social accessibility related barriers that may hold vulnerable women back from using services. The chapter argues that while societal level problems require solutions at the societal level, health services need to do their bit too.

Chapter 9 discusses the findings by drawing on and linking to the theoretical literature on how social norms shape reproductive behavior and action. It does so within the unique context of South Sudan – a context overwhelmingly defined by a state of chronic and ongoing insecurity and related uncertainty. The chapter discusses how social norms are conduits for the expression of social structural forces and help maintain and reproduce societal structures and relational arrangements, including in the reproductive realm, often to the disadvantage of women. It is argued that while social norms have a powerful influence on the reproductive health related behaviours of individuals, this influence is contingent upon the context broadly and the unique context of the individual or group the norm operates on. Building on the findings presented in Chapters 4-8, it is argued that while social norms shape the actions of individual in a wide range of complex way, individuals, no matter how constrained they might be, do not passively subject themselves to these societal structural forces. Instances of women and adolescent girls active sensemaking of their circumstances, and covert and overt acts to re-negotiate and subvert the structural constraints in their own interests, are used to illustrate women's and girls' active exercise of agency, in the face of overwhelming odds. The findings which show the contingent and conditional nature of social norms and gender relations are held up against theoretical insights about norm change to argue that social and gender norms, even those which appear deeply entrenched and immutable, are mutable, and amenable to intervention and change. The paradoxically positive aspects of the conflict and ensuing social disruption that South Sudan has experienced over the years, are also discussed. The chapter dwells upon how the disruption has weakened many social norms in Fertit society, and how it has inadvertently catalyzed conditions that have allowed the existing social and gender norms on reproduction and childbearing and family size to come under pressure from competing social norms. It exposes and discusses how the uncertainty and instability is being mobilized by men and women to renegotiate gender relations in Fertit society. The chapter reiterates that the imminent return of
SUMMARY

Peace and stability will create opportunities for men and women to challenge and reconfigure existing social and gender norms. It concludes that now is the right time for reproductive health policy makers and program managers to work with the insights generated from this research to trigger norm change such as to promote sustainable improvements in reproductive health in South Sudan. Throughout, where applicable and as appropriate, implications for action for reproductive health policy and practice in South Sudan, and for further research, are drawn. These are summarized below.

Overall, findings show how the consanguinal nature of the Fertit family unit shapes people's actions in the reproductive realm. Findings reveal the centrality of this social reality to many a reproductive health related decision-making process in Fertit society. To be effective, reproductive health policy and practice in Western Bahr el Ghazal, and in many similar contexts of South Sudan, needs to reorient itself to this reality. For instance, health promotion activities should be targeted simultaneously at the reproductive woman and the members of her husband's family, and carefully tailored to the context. The family structure means that women continue to be close to their siblings and remain an integral part of their father's or brother's family unit; social policy interventions for gender equality can leverage this relational arrangement and mobilise societal support by strategically invoking these relationships. Findings that entrenched norms related to reproductive health are under pressure from competitive and contradictory norms, suggests that social conditions are ripe for intervention towards norm change. For instance, health promotion campaigns could focus on promoting a family ideal in which children become the object of parental investment, rather than focusing directly or solely on reducing family size. Findings suggest that (1) a multisectoral response that facilitates girls and women's education, (2) economic interventions that enable women's active participation in the economy, and (3) political and broader societal interventions which pave the way for greater and meaningful participation of women in public life, are required. South Sudan's development partners should actively support the operationalisation of the ambitious agenda articulated in South Sudan's National Gender Policy. The young mothers who participated in this study overwhelmingly wanted to continue their education. South Sudan's Ministry of General Education and Instruction, as it develops its 2018-2023 Strategic Plan, should therefore include measures which systematically enable young mothers to continue schooling. South Sudan's development partners are well placed to engage with the Ministry to ensure this. Findings also suggest that in spite of entrenched patriarchy, there is some openness to joint decision-making on reproductive matters. More broadly, the conditions in South Sudan might be ripe for a broader recalibration of social and gender relations to occur. Interventions which promote dialogue among couples, and among the man's family members, could be a feasible and effective way forward to enhance women's say in reproductive matters. Similarly, explicit social policy interventions which target men, and promote critical dialogue in society about masculinities and patriarchy, can pave the way for a more gender equitable society. The findings that many women, particularly the most vulnerable ones might be worn down by the constant micro insults and violations of their social dignity, and therefore avoiding venturing out to seek care, are serious and require prompt and concerted attention. Local health and social services
and the NGOs providing health services need to collaborate to consciously identify the most vulnerable women in society, and to support them to access health services without fear. South Sudan's development partners can contribute to this through explicitly incorporating in their strategic planning provisions to make and shape health facilities into social spaces for dignity promotion, for one and all.

The study raises many questions too. For instance, as South Sudan extricates itself from conflict, and as the overwhelming structural influence of conflict and uncertainty recedes, structural forces hitherto in the background, will come to the fore; these will once again exert influence to reshape the nature, structure and relational arrangements within the Fertit society. Research which draws together theoretical insights and insights from empirical work from settings which have experienced similar transitions, will be very valuable from a policy perspective, including but not limited to reproductive health policy. While it is argued that the entrenched gender order is under stress and that there is an opportunity for intervention to reconfigure the unequal gender order, the complexity of the situation and the need for a cautious and informed approach are also highlighted. The caution relates very much to the major knowledge gaps around the construction and dynamics of masculinity and patriarchy in the Fertit society; the need for in-depth research on this subject is critical (to inform public policy) given the violent history of the country. Questions around who wields the most influence in reproductive decisions within 'consanguinal' family units, and how best to leverage this influence in a way that enhances gender equality and social well-being, require further research. That many women prioritized their dignity over everything else, including matters sacrosanct i.e. the health of the unborn child, raises many questions. Women's fears of their dignity being violated require explorations into the locally appropriate ways and means to both allay these fears, and to reconfigure health service provision.
DANKWOORD
This study was possible only because the SHARP project and the research were implemented with active involvement of NGO implementing partners, county health departments, state ministry of health, national ministry of health, international organisations, and local researchers. Without their active and continuous involvement at multiple levels, neither the SHARP project nor this research would have been possible.

The direct and indirect contributions of: SHARP project implementing partner NGOs (HealthNet TPO, International Medical Corps, and Cordaid); colleagues and collaborators at the National Ministry of Health, Juba, South Sudan; colleagues and collaborators at the State Ministry of Health, Wau, Western Bahr el Ghazal, South Sudan; the Hon. Minister of Health of WBeG state, Dr Isaac Cleto Hassan Rial; the Director of Primary Care at State Ministry of Health, Wau, Western Bahr el Ghazal, South Sudan, Mr Henry Sasa; colleagues and collaborators at the County Health Departments of Wau County, Western Bahr el Ghazal, South Sudan; colleagues and collaborators at the University of Bahr el Ghazal, Wau; and, SHARP project colleagues at KIT, are duly and wholeheartedly acknowledged.

The SHARP project was funded by a grant from the Ministry of Foreign Affairs and Development Cooperation of the Kingdom of The Netherlands, to KIT Royal Tropical Institute, the Koninklijk Instituut voor de Tropen, Amsterdam, The Netherlands. Thanks are due to KIT for providing the opportunity, the platform, the support and the environment for the conduct of this study. Without the cooperation and support of all my colleagues at KIT Health, KIT Education, and KIT Project Support Unit, this work would have not been possible. I owe them all a debt of gratitude.

Immense thanks are due to South Sudanese colleagues and partners in Wau: Dr. Matilda Rial, Ms. Kaidi Rial, their wise mother, Mr. Anthony Julu Matere, Ms. Angelina Rene, Mr. James Dona. I am sincerely grateful for their generosity in sharing their knowledge, wisdom, insights and contacts.
I studied medicine at a rural medical school in India (1991-1997). In 2005, I completed my specialist training program in dermatology and venereology from University of Mumbai, and College of Physicians & Surgeons of Bombay, in India. During this period, I won the First Prize at the ‘Young Dermatologists Forum’ of the 2004 national conference of the Indian Association of Dermatologists, Venereologists and Leprologists. It was during my specialist training, that I became interested in public health and public health research – two experiences triggered this interest. The first related to the research I did on Leprosy for my doctoral thesis in Dermatology, and the second related to my extensive involvement in the care of persons living with HIV, particularly those from the LGBTI community. In my first post-doctoral appointment, I led the India country site of a large US-NIH funded randomised control trial of a behavioural intervention for HIV prevention (RO1). Here I recognised the importance of and developed a keen interest in health systems and health development – I decided to pursue further studies in health development and enrolled for the MPH program at KIT Royal Tropical Institute, Amsterdam. I graduated at the top of my MPH class, summa cum laude.

In 2008, I joined KIT Royal Tropical Institute, Amsterdam as an Advisor. At KIT, between 2008 and 2017, I was involved in a wide variety of research, advisory, and teaching projects. For instance, between 2009-2013, I was part of an FP7 research project (HESVIC) which studied health policy processes and regulation in Vietnam, India and China. Similarly, in 2012, I contributed to winning a major H2020 research grant (REACHOUT) which examined pathways to maximise the equity, effectiveness and efficiency of close-to-community services in Asia and Africa. In 2012, I led the successful grant application for the South Sudan Health Action and Research Project (SHARP); eventually, I took on the role of the lead on the operational research component of SHARP. The work presented in this thesis relates to the research on social and gender norms and women’s reproductive health, done as part of the SHARP project in South Sudan. Since 2013, I have conducted studies on trust relations in the health system and on the state of the medical profession in India; in this period, I have also been involved in researching the performance and motivation of health workers in Uganda, Zimbabwe and India. At KIT I was also involved in work which entailed translation of research to inform global health policy and practice. For instance, I led the policy review of Swedish International Development Agency’s framework support to the global Maternal Health Thematic Fund; at a different level, I conducted a policy and strategy review of Netherlands Leprosy Relief’s India program to inform their strategic plans going forward. Throughout my time at KIT, I was part of the core team leading the delivery of the International Course in Health Development (ICHD-MPH) program. I played key roles in developing two tracks in the MPH program - in 2012, the Sexual & Reproductive Health Track, and in 2009, the HIV & AIDS Track. I cherish my involvement in the ICHD-MPH and consider it one of the most fulfilling experiences of my professional life.

In 2018, I joined the Melbourne School of Population and Global Health, of the University of Melbourne, Australia.
Royal Tropical Institute  
KIT Development Policy & Practice

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Our reference KIT Health  
Amsterdam Thursday, 12 June 2014

Subject Fina Decision Research Ethics Committee on Proposal S51

Dear Sumit Kane,

The Research Ethics Committee of the Royal Tropical Institute (REC) has re-reviewed the revised proposal entitled “Gaining context specific and nuanced understanding of norms, preferences, and expectations about sexual and reproductive health and about related services in South Sudan” (S51) that was resubmitted on June 5th, 2014.

The decision of the Committee is as follows:

The reviewers agreed that all comments made by the REC were addressed and were satisfied with the clarifications.

The proposal is approved.

We hope to have informed you sufficiently and wish you success with the study.

Kind regards,

P. Baatsen, MA  
Chair Research Ethics Committee, KIT

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We think. We share. We act.
The Republic of South Sudan

Ministry of Health

To: Ms. Lisa Woods, MScPH, MA
Principle Investigator
Country Coordinator
SHARP Consortium

2nd October, 2014

Dear Ms. Woods

RESEARCH APPROVAL LETTER

STUDY ON GAINING CONTEXT SPECIFIC AND NUANCED UNDERSTANDING OF NORMS, PREFERENCES AND EXPECTATIONS ABOUT SEXUAL AND REPRODUCTIVE HEALTH, AND ABOUT RELATED SERVICES IN WESTERN BAHR EL GHAZAL STATE.

I am writing in response to the request for authorization to the study on: Gaining Context Specific and Understanding of Norms, Preferences and Expectations about Sexual and Reproductive Health and about related services in Western Bahr el Ghazal State, South Sudan. As part of your secondary data analysis in health seeking behavior and reproductive health practices, particularly in relation to social characteristics such as gender and local power structures.

After close review on the proposal, I am glad to inform you that the ethical committee at the Ministry of Health, Republic of South Sudan has approved the study. The Ministry acknowledges the need to explore local norms, preferences and decision-making processes around sexuality, reproductive and reproductive choices among women and men in communities of WBEG. Please, keep the Ministry of Health, Republic of South Sudan informed on the outcome of the study.

I look forward to the report and recommendations that will be generated from the study. Note that the study should not be published without the consent of the Ministry of Health, Republic of South Sudan.

Yours sincerely

Dr. Richard Lino Lako
Director General
Policy, Planning, Budgeting and Research
Ministry of Health
Republic of South Sudan

cc: Under Secretary, MOH-RSS
    Director Generals, WBG State
    Director General, Reproductive Health

Headquarters, Ministerial Complex. Juba, South Sudan - P.O.Box 88, Juba.
Tel: +211 (0) 177 800 281 / +211 (0) 177 800 278
ANNEXURES III: FOCUS GROUP DISCUSSION AND INTERVIEW TOPIC GUIDES

Topic Guide: FGD Community Members

DATE ..........................................................................................................................Code:
Time interview/ FGD started ..........................................................
Time interview/ FGD ended ..........................................................
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ANNEXURES

» What can a family do to space their children? (Both health service related and community habits/ beliefs/ practices). Are there any differences in what male and female community members think on this? Are there differences in how younger and older people think about this? What all influences people's choices?)

» What will a family do when the wife is pregnant? (Both health service and not health services related)

» (Are there any differences in what male and female community members think on this? Who makes these decisions? How are differences in preferences and choices resolved? What all influences people's choices?)

If in union:

» Do you think that young people should be able to get information on sexuality and reproductive issues? How and from whom do young people obtain this information? Are there any taboos related to sexual and reproductive health?

If not in union:

» How and from whom do you obtain information on sexuality and reproductive issues? Are you using/ allowed to use contraceptives? Are there any taboos related to sexual and reproductive health?

Decision making

» How and by whom are decisions made regarding reproductive health in households in your community (child spacing, pregnancy, childbirth)? Why? What is the role of the wife, the husband, and other family or community members?

» How and by whom are decisions being made regarding seeking care from services (public and private health providers, for example delivery services/ contraceptive use)? Why? What is the role of the wife, the husband, and other family or community members?

» What do you think about the roles of these people in decision making? (Should it stay like this, should it change and why?)

» (If that is the case) - Why do you think some people don't go to the health facility for reproductive health issues? Probe around: costs, customs, TBAs.

Preferences and expectations

» What are your expectations regarding reproductive health services? Probe around:
  • Place? (Facility/ Community)
  • Price?
  • Who should be targeted?
  • Staff attitude?
  • Services available?
  • Commodities available?
  • Etc.
Current health services

» What are your experiences with the reproductive health services that are currently offered in your area? (Good/ bad experience, why?)
» Based on your experiences, will you visit the health centre next time, or would you recommend others to go there?
» Can everybody in the community equally access reproductive health services? (Physical access, financial access)? Are certain groups left out? If yes, who are these groups?
» Do the current reproductive health services take into account the wishes of the community? Why or why not? Could you give examples?
» Do the current reproductive health services sufficiently take into account the norms, customs and beliefs of your community? Why or why not? Could you give examples?
» What should be changed in the current reproductive health services to improve their use?
» What else could be done to address some of the problems of pregnant women and young mothers in the community?

Community-based reproductive health services

» In your community, are pregnant women delivering with TBAs? Why do they choose a TBA above facility services? (What is the advantage of delivering in a facility and what is the advantage of delivering with a TBA? Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)
» What makes a woman a TBA? (Probe around received training, position within the community)
» Which services are offered by TBAs? How do they earn for their living?
» Do midwives ever conduct home deliveries? Do midwives work together with TBAs? How does that go?
» Are there any other community health workers where pregnant women and young mother can get help? (Home Health Promoters? Others? Who are they? Which services do they offer and what is your opinion about their services?)
Topic Guide: FGD Health Facility Personnel

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Time interview/ FGD ended ...........................................
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Norms and beliefs

» In this area, what do community members think and believe regarding sexual and reproductive health?
  · Sexuality (womanhood, manhood)
  · Pregnancy (being pregnant, fatherhood, care during pregnancy)
  · Where to deliver (and seeking emergency obstetric care)
  · Sexuality education – for different groups

» Are there any differences between male and female? If yes, why?

» Are there any traditional practices and taboos that in your view could affect reproductive health of people in this area? Please explain – both hindering and facilitating aspects.
Decision making

» How and by whom are decisions being made regarding reproductive health and the use of services? Why? What is the role of the wife, the husband, and other family or community members?

» What do you think about the roles of these people in decision making? (Should it stay like this, should it change (and if yes: how) and why?)

» Why do you think some people don’t go to the health facility for reproductive health issues?

Current health services

» According to you, what is the quality of the reproductive health services in this area? (Availability of staff, training of staff, infrastructure, commodities etc.)

» Can everybody in the community equally access reproductive health services? (Physical access, financial access, are certain groups left out?)

» Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Examples?

» Do the current reproductive health services sufficiently take into account the norms, customs and beliefs of the community? Why or why not? Examples?

» How does facility management get to know the preferences and the opinion of the community on the services delivered? (Community meetings? Suggestion box? Other?)

» What should be changed in the current reproductive health services to improve their use?

» What else could be done to address some of the problem related to reproductive health in the community?

Community-based reproductive health services

» In your community, are pregnant women delivering with TBAs? Why do they choose a TBA above facility services? (Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)

» What makes a woman a TBA? (Probe around received training, position within the community)

» Which services are offered by TBAs? How do they earn for their living?

» Do midwives ever conduct home deliveries? Do midwives work together with TBAs? How does that go?

» Are there any other community health workers where pregnant women and young mother can get help? (If yes: who are they? Which services do they offer and what is your opinion about their services? If no: do you think community-based health workers are needed in de delivery of SRH services?)
ANNEXURES

Topic Guide: Semi Structured Interview with Community Members

DATE ............................................................................................................Code:
Time interview/ FGD started .................................................................
Time interview/ FGD ended .................................................................
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Gender
Age
Marital status
Number of children
Religion
Name of village
Catchment area
Use of health services in past 3 months (Y/N)
Kind of health services used in past 3 months

Norms and beliefs

» What does being a man/woman mean in your community? When does a girl become a woman and a boy a man?
» When and why do people get married?
» When can and should a couple have children? Are there views regarding the timing and number of children? (Probe on the possible influence of polygamy regarding the desired number of children)
» Are there times when one can say that pregnancy is not desirable? Is abortion acceptable in your community? To you?
» What can a couple do to space their children? (Both health service related and community habits/ beliefs/ rituals)
» According to you, what is a family?
» What will a family do when the wife is pregnant? (Both health service and not health services related, timing of looking for ANC, other assistance) What influences people’s choices? What do you think about these influences?

If in union:
» Do you think that young people should be able to get information on sexuality and reproductive issues? How and from whom do young people obtain this information? Are there any taboos related to sexual and reproductive health?

If not in union:
» How and from whom do you obtain information on sexuality and reproductive issues? Are you using/ allowed to use contraceptives? Are there any taboos related to sexual and reproductive health?

**Decision making**
» In your family, how are decisions regarding reproductive health made (what happens in case of child spacing, pregnancy, childbirth)? Why? What is the role of the wife, the husband, and other family or community members?
» In your family, how and by whom are decisions being made regarding seeking care from services (public and private health care providers, for example child spacing, antenatal care or delivery services)? Why? What is the role of the wife, the husband, and other family or community members?
» What do you think about the roles of these people in decision making? (Should it stay like this, should it change and why?)
» Why do you think some people don’t go to the health facility for ANC or delivery services? Probe around: costs, customs, TBAs.

**Preferences and expectations**
» What are your expectations regarding reproductive health services? Probe around:
  · Place? (Facility/ community)
  · Price?
  · Who should be targeted?
  · Staff attitude?
  · Services available
  · Commodities available
  · Etc.

**Current health services**
» What are your experiences with the reproductive health services that are currently offered in your area? (Good/ bad experience, why?)
Based on your experiences, will you visit the health centre next time, or would you recommend others to go there?

Can everybody in the community equally access reproductive health services? (physical access, financial access, are certain groups left out? If yes, who are these groups?)

Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Could you give examples?

Do the current reproductive health services take into account the wishes of the community? Why or why not? Examples?

What should be changed in the current reproductive health services to improve their use?

What else could be done to address some of the problems of pregnant women and young mothers in the community?

**Community-based reproductive health services**

If in union having child(ren):

» Did you ever deliver a baby with help of a TBA? Why did you or why did you not? (What is the advantage of delivering in a facility and what is the advantage of delivering with a TBA? Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)

If not having child (ren):

» In your community, are pregnant women delivering with TBAs? Why do they choose a TBA above facility services? (What is the advantage of delivering in a facility and what is the advantage of delivering with a TBA? Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)

» What makes a woman a TBA? (Probe around received training, position within the community)

» Which services are offered by TBAs? How do they earn for their living?

» Do midwives ever conduct home deliveries? Do midwives work together with TBAs? How does that go?

» Are there any other community health workers where pregnant women and young mother can get help? (Home Health Promoters? Others? Who are they? Which services do they offer and what is your opinion about their services?)
**Topic Guide: Semi Structured Interview with Adolescents**

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Gender
Age
Marital status
Number of children
In School or Not in School
Religion
Name of village
Catchment area
Use of health services in past 3 months (Y/N)
Kind of health services used in past 3 months

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**Topics to be covered with adolescent girls/young women**

**Norms and beliefs**

- What in your view defines health, good health?
- How would you define a healthy (young) man, a healthy (young) woman?
- What is important in your/young women's lives? Does this differ from what is important in other, older or married women's lives? Reasons why this is important (probe).
- What does being a woman mean to you? To young people generally in your circle? When does a girl become a woman and a boy a man?
- What do girls think is expected of them? Probe by:  
  - By boys? By families? By society?
ANNEXURES

- Probe on: What they think of these expectations? How do they navigate these expectations? What strategies do they use to get what they want? To subvert social expectations and norms which they do not agree with?

» Who decides whom a girl can have sexual relations with? Should parents, society have a say in this?
  - Probe into factors influencing, or reasons behind, girls having sex with boys or older men.
  - Probe into - Are girls ever forced to have sexual relations? Are there situations where it is OK for a man to insist on having sex?

» What does it mean for a girl to get pregnant?
» What does becoming a mother mean to you? To young people in your community? Do young people think differently from the older folks?
» Do girls in your circle want to become pregnant?
  - Probe into views on the decision to become pregnant - whether there is a decision at all, what shapes this decision?
  - Probe into why this is the case.

» How do others (probe about other boys, girls, family, society) view a situation where a girl is pregnant? (Probe about – is she congratulated/appreciated/reprimanded/looked down upon)
» Probe into – what they think are effects of pregnancy on adolescent girls (psychological, material, social, including social position and status, effects and also relational effects with the young mother, family, child)
» Probe about – views on this new responsibility, fears, stresses, worries, aspirations, for themselves, for their child (as partners, as mothers or would be mothers)
» Probe about - the ways young mothers/pregnant girls talk about their responsibilities, fears, stresses, worries, aspirations for themselves, for their child;
» What can one do to avoid getting pregnant? (Both health service related and in terms of community practices/beliefs/rituals) What do young people do to avoid pregnancy? (Views on importance of protection, Types of protection, Double protection etc)
» Are young women using/able to use contraceptives? Are there any taboos related to sexual and reproductive health when it comes to young people buying or getting contraceptives?
  - What method do young women in your circle prefer to use?
  - Are male partners also using condoms?

» What will a family do when a girl in the family gets pregnant? Or a boy in the family impregnates a girl? (Both socially and in terms of health services related eg timing of
looking for ANC, other assistance) What influences people’s choices? What do you think about these influences?
» Is abortion acceptable amongst young people in your community? To you? Do young people think differently from the older folks?

Views about health services
» Are you, and young people generally, able to get information on sexuality and reproductive issues? How and from whom do you obtain this information?
» Do you think that young people should be able to get information on sexuality and reproductive issues? How and from whom do you, and youth in your circle, prefer to obtain this information?
» Should information and knowledge about sex, sexuality and reproduction be given in schools? From when on?
» Where do you go when you need healthcare? Do you have somewhere to turn to when you need services related to sexual and reproductive health? Where do young people go? Probe around: access (physical, social), costs, customs.
» How do adolescents view available SRH services? Whether they use these, and what facilitates or hinder access to these services?

Preferences and expectations
» What are your and young people's expectations regarding sexual and reproductive health services? Probe around adolescents’ expectations regarding:
  · Place (Facility/ community)
  · Price
  · Who should be targeted?
  · Staff attitude?
  · Services available
  · Commodities available.

Topics to be covered with adolescent boys/young men

Norms and beliefs
» What in your view defines health, good health?
» How would you define a healthy (young) man, a healthy (young) woman?
» What is important in your/young men’s lives? Does this differ from what is important in other men’s lives/women’s lives? Reasons why this is important (probe).
» What in your view makes a boy a man?
  · Probe to - Unpack and understand what boys understand as socially normative and expected of them.
  · Probe into the types of social and cultural events that influence sexual behaviours (marriages, dance, ceremonies)
· Probe into - norms and values around sexual relationships (perceptions about self, girls and sexual relationships).
· Probe into - What role socio-economic factors plays in young boys' sexual behaviours (poverty, unemployment, literacy, urbanization, changes in family dynamics, etc.)
· Probe to - Understand to what extent does heterosexual boys’ masculinity ideology shapes their sexual decision making, and how they treat female sexual partners.
· Probe to - see if the new heterosexual relations are primary spaces for demonstrating manhood and proving masculinity), use of condoms, risk taking (and enquire if there other spheres where they can prove this).
· Probe to - enquire into how boys understand what is normatively expected of them (injunctive norms).
· Probe to – explore how boys distinguish this from what they see around them (subjective norms). Disentangle where possible by society and adult men, and peers.

» Do you agree with how society expects you/young men to behave and to do? If the answer indicates struggles (with accepting the expectations, or with the contradiction between injunctive and subjective norms), then probe.
· What sanctions do you worry about if you happen to not confirm to these norms (sanctions from peers, family, society)? Are the consequences substantive?
· What strategies do young men resort to, to subvert and bypass norms which they do not agree with?

» What does it mean for a boy to get a girl pregnant? How do others (probe about other boys, girls, family, society) view a situation where a boy gets a girl pregnant?
· Probe into – their (or if possible of someone they know’s) experiences dealing with pregnancy (socially, culturally and emotionally,...what happens when your girl told you she is pregnant?)

» Do boys in your circle want to become fathers? To make girls pregnant?
· Probe into views on the decision to become a father - whether there is a decision at all, what shapes this decision? Why do boys want to father at such young age?

» Probe into – what kind of effects adolescent fatherhood has on the boys (psychological, material, social including social position and status, effects and also relational effects with the young mother, family, child);
» How do you/young men look at your/their pregnant mates (as partners, as wives, as just some girl you are stuck with because she got pregnant etc);
· Probing to - chart the ways young fathers talk about their responsibilities, fears, stresses, worries, aspirations, for themselves, for their child (as partners, as would be fathers)
» What can one do to avoid getting pregnant? (Both health service related and community habits/ beliefs/ rituals) What do young people do to avoid pregnancy? (Views on importance of protection, Types of protection, Double protection etc)
» Are young people using/ able to use contraceptives? Are there any taboos related to sexual and reproductive health when it comes to young people accessing contraceptives?
» What will a family do when a girl in the family gets pregnant? Or a boy in the family impregnates a girl? (Both socially and in terms of health services related eg timing of looking for ANC, other assistance) What influences people’s choices? What do you think about these influences?
» Is abortion acceptable amongst young people in your community? To you? Do young people think differently from the older folks?

About health services
» Are you, and young people generally, able to get information on sexuality and reproductive issues? How and from whom do you obtain this information?
» Do you think that young people should be able to get information on sexuality and reproductive issues? How and from whom do you, and youth in your circle, prefer to obtain this information?
» Where do you go when you need healthcare? Do you have somewhere to turn to when you need services related to sexual and reproductive health? Where do young people go? Probe around: access (physical, social), costs, customs.

Preferences and expectations
» What are your and young people’s expectations regarding sexual and reproductive health services? Probe around adolescents’ expectations regarding:
  · Place (Facility/ community)
  · Price
  · Who should be targeted?
  · Staff attitude?
  · Services available
  · Commodities available.
ANNEXURES

Topic Guide: SSI Traditional Leaders

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Role
Gender
Age
Marital status
Religion
Name of village
Catchment area

___

Norms and beliefs

» According to you, what should a family look like? (When should a couple start a family, is there a preference regarding number of children?)
» What can a family do to space their children? (Both health service related and community habits/ beliefs/ rituals)
» What will a family do when the wife is pregnant? (Both health service and not health services related)
» What are the traditional beliefs related to sexual and reproductive health? Are there any taboos? If yes, can you give an example?
» Do men and women think different about issues around sexuality and reproductive health? Why?
» How does religion influence people’s choices? What do you think about that? Probe: do clergymen have influence on people’s sexual and reproductive health choices? Is this influence different for young/ old people, men/women?
Do you think that young people should be able to get information on sexuality and reproductive issues? How and from whom do young people obtain this information?

Decision making

In your area, who in the household/community is making decisions regarding reproductive health (what happens with child spacing, pregnancy, childbirth)? Why? What is the role of the wife, the husband, and other family or community members?

In your area, how and by whom are decisions being made regarding seeking care from services (public and private health care providers, for example child spacing, antenatal care or delivery services)? Why? What is the role of the wife, the husband, and other family or community members?

What do you think about the roles of these people in decision making? (Should it stay like this, should it change and why?)

Why do you think some people don’t go to the health facility for reproductive health issues?

What is your role in the community regarding choices of people and health seeking behavior related to reproductive health?

Preferences and expectations

What are your expectations regarding reproductive health services? Probe around:

- Place? (Facility/community)
- Price?
- Who should be targeted?
- Staff attitude?
- Services available
- Commodities available
- Etc.

Current health services

What are your experiences with the reproductive health services that are currently offered in your area? (Good/bad experience, why?)

Can everybody in the community equally access reproductive health services? (Physical access, financial access, are certain groups left out and if yes, who are these groups?)

Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Could you give examples?

Do the current reproductive health services sufficiently take into account the norms, preferences and beliefs of the community? Why or why not? Could you give examples?

What should be changed in the current reproductive health services to improve their use?

What else could be done to address some of the problems related to reproductive health in the community?
Community-based reproductive health services

» In your community, are pregnant women delivering with TBAs? Why do they choose a TBA above facility services? (What is the advantage of delivering in a facility and what is the advantage of delivering with a TBA? Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)

» What makes a woman a TBA? (Probe around received training, position within the community)

» Which services are offered by TBAs? How do they earn for their living?

» Do midwives ever conduct home deliveries? Do midwives work together with TBAs? How does that go?

» Are there any other community health workers where pregnant women and young mother can get help? (Home Health Promoters? Others? Who are they? Which services do they offer and what is your opinion about their services?)
Topic Guide: Semi Structured Interviews with Health personnel

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Job title
Gender
Age
Marital status
Religion
Name of health facility
Catchment area

Norms and beliefs
» In this area, what do you think and believe regarding sexual and reproductive health?
  · Ideal family composition (including size)
  · What to do in case of pregnancy
  · Where to deliver
  · Sexuality education for youth

» Are there any differences between male and female? What do you think about that?
» How does religion influence people's choices? What do you think about that? Probe: do clergymen have influence of people's sexual and reproductive health choices? Is this influence different for young/ old people, men/women?
» Are there any traditional practices and taboos that could hinder reproductive health of people in this area?
ANNEXURES

**Decision making**

» How and by whom are decisions being made regarding reproductive health and the use of services? Why? What is the role of the wife, the husband, and other family or community members?

» What do you think about the roles of these people in decision making? (Should it stay like this, should it change (and if yes: how) and why?)

» Why do you think some people don’t go to the health facility for reproductive health issues? Probe around: costs, customs, TBAs.

**Community-based reproductive health services**

» In your community, are pregnant women delivering with TBAs? Why do they choose a TBA above facility services? (What is the advantage of delivering in a facility and what is the advantage of delivering with a TBA? Probe around: TBAs’ ability in case of emergency situations, TBAs’ link with traditions and cultural practices)

» What makes a woman a TBA? (Probe around received training, position within the community)

» Which services are offered by TBAs? How do they earn for their living?

» Do midwives ever conduct home deliveries? Do midwives work together with TBAs? How does that go?

» Are there any other community health workers where pregnant women and young mother can get help? (If yes: who are they? Which services do they offer and what is your opinion about their services? If no: do you think community-based health workers are needed in de delivery of SRH services?)

**Current health services**

» Question about the quality of the reproductive health services in this area? (Availability of staff, training of staff, infrastructure, commodities etc.)

» Can everybody in the community equally access reproductive health services? (physical access, financial access, are certain groups left out and if yes, who are these groups?)

» Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Could you give examples?

» Do the current reproductive health services sufficiently take into account the norms, customs and beliefs of the community? Why or why not? Could you give examples?

» How does facility management get to know the preferences and the opinion of the community on the services delivered? (Community meetings? Suggestion box? Other?)

» What should be changed in the current reproductive health services to improve their use?

» What else could be done to address some of the problems related to reproductive health in the community?
Topic Guide: Semi Structured Interview with State/County level SRH Services Managers

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Time interview/ FGD ended ......................................................
Duration .......................................................................................minutes

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Job title
Gender
Age
Marital status
Religion

SRH priorities and service delivery

» What are the most important SRH services delivered in this state? (From community-based up till BEmOc and CEmOC)
» On which policies are these services based?
» Who is delivering these services (Government, NGOs; Most important cadres of health workers)
» Where are these services delivered? (Types of facilities)
» What is your role in the delivery of these SRH services?
» Which measures are taken to ensure quality reproductive health services? (Guidelines, professional development etc.)

Community-based reproductive health services

» What roles do TBAs have regarding SRH? Do you promote links between facilities and TBAs? What goes well and what does not go well regarding TBAs in the community?
ANNEXURES

» Are there any other community health workers where pregnant women and young mothers can get help? (Home Health Promoters? Others?) (If yes: who are they? Which services do they offer and what goes well and what needs further improvement? If no: do you think community-based health workers are needed in the delivery of SRH services?)

Current health services

» According to you, what is the quality of the reproductive health services in this area? (Availability of staff, training of staff, infrastructure, commodities etc.)
» Can everybody in the community equally access reproductive health services? (Physical access, financial access, are certain groups left out and if yes, who are these groups?)
» Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Could you give examples?
» Do the current reproductive health services sufficiently take into account the norms, customs and beliefs of the community? Why or why not? Could you give examples?
» How does the County Health Department and the State Health Department get to know the preferences and the opinion of the community on the services delivered? Do they take suggestions into account?

Constraints and recommendations

» What are the biggest constraints in service delivery? (Infrastructure, human resources, commodities, finance)
» What are the biggest constraints in social access to services? What are the reasons that community members are not making use of the services? (Cultural norms, preferences, expectations)
» What should be changed in the current reproductive health services to improve their use?
» What else could be done to address some of the problems related to reproductive health in the community?
Topic Guide: Semi Structured Interview with NGO Representatives

DATE ..........................................................................................................................Code:
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SRH priorities and service delivery
» What are the most important SRH services delivered in this state? (From community-based up till BEmOc and CEmOC)
» On which policies are these services based?
» Who is delivering these services (Government, NGOs; Most important cadres of health workers)
» Where are these services delivered? (Types of facilities)
» What is your role in the delivery of these SRH services?
» Which measures are taken to ensure quality reproductive health services? (Guidelines, professional development etc.)

Community-based reproductive health services
» What roles do TBAs have regarding SRH? Do you promote links between facilities and TBAs? What goes well and what does not go well regarding TBAs in the community?
ANNEXURES

» Are there any other community health workers where pregnant women and young mother can get help? (Home Health Promoters? Others?) (If yes: who are they? Which services do they offer and what goes well and what needs further improvement? If no: do you think community-based health workers are needed in the delivery of SRH services?)

Current health services

» According to you, what is the quality of the reproductive health services in this area? (Availability of staff, training of staff, infrastructure, commodities etc.)
» Can everybody in the community equally access reproductive health services? (Physical access, financial access, are certain groups left out and if yes, who are these groups?)
» Do the current reproductive health services sufficiently take into account the preferences of the community? Why or why not? Could you give examples?
» Do the current reproductive health services sufficiently take into account the norms, customs and beliefs of the community? Why or why not? Could you give examples?
» How does the County Health Department and the State Health Department get to know the preferences and the opinion of the community on the services delivered? Do they take suggestions into account?

Constraints and recommendations

» What are the biggest constraints in service delivery? (Infrastructure, human resources, commodities, finance)
» What are the biggest constraints in social access to services? What are the reasons that community members are not making use of the services? (Cultural norms, preferences, expectations)
» What should be changed in the current reproductive health services to improve their use?
» What else could be done to address some of the problems related to reproductive health in the community?