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 (Itayyar & 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, Tanyag (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, McAlaney & Jenkins
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2015, Ahmed et al 2016). 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 & Trout’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.
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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 chapters 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 (Cialdini et al 1990; Kallgren et al 2000), theories of fertility and demographic change (Caldwell 1976, Caldwell & Caldwell 1987), and from theories of masculinity (Connell
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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.
REFERENCES


INTRODUCTION


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