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 connotated 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 connotated. 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
economic; 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 fulfillment 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 Mc Nicoll (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. Mc Nicoll argued that these institutional arrangements interact to shape individual action (Mc Nicoll 1994). Greenhalgh (1995) qualified Mc Nicoll'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, Gialdini'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
Research Design

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
CHAPTER 3

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 (Calidini 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; Oeywumi 1998, 2002, 2011; Morrell 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.
**RESEARCH DESIGN**

*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
CHAPTER 3

(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 (Rural; Peri Urban)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Community members: Female 18-35 years (Not in union*)</td>
<td>1 (R: P)</td>
</tr>
<tr>
<td></td>
<td>Community members: Female 18-35 years (In union)</td>
<td>1 (R)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male above 35 years</td>
<td>1 (R)</td>
</tr>
<tr>
<td></td>
<td>Community members: Male 18-35 years</td>
<td>1 (P)</td>
</tr>
<tr>
<td></td>
<td>Health workers</td>
<td>1 (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 a 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. Dever’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 Ferit 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/PGD 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 Furit 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.
REFERENCES


Devers, KJ. (1999). How will we know “good” qualitative research when we see it? Beginning the dialogue in health services research. Health Services Research. 34(5-2): 1153-1188.


RESEARCH DESIGN


Urdal, H., Che, PC. (2013). War and Gender Inequalities in Health: The Impact of Armed
CHAPTER 3


