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CHILD SPACING & FAMILY PLANNING IN SOUTH SUDAN:
KNOWLEDGE, ATTITUDES, PRACTICES AND UNMET NEED

SEPTEMBER 2011

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This report is dedicated to Molly Mayo Gingerich, who assisted USAID in saving women's lives across the globe. It was the memory of her tireless efforts that inspired and gave courage and determination to overcome the many challenges of this research, especially in Upper Nile State when slogging through deep mud, ankles bleeding from rough mud-boots, and waging an unsuccessful struggle to fight off malarial mosquitoes.

Barbara Pillsbury

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ANNEXES

TABLES

ACRONYMS

ANC	Antenatal care
AIDS	Acquired immune deficiency syndrome
ARC	American Refugee Committee
CBD	Community-based distribution; community-based distributor
CBO	Community-based organization
CHD	County Health Department
CHW	Community health worker
CPA	Comprehensive Peace Agreement
CPR	Contraceptive prevalence rate
FGD	Focus group discussion
FHI	Family Health International
GOSS	Government of South Sudan
HIV	Human immune deficiency virus
HTSP	Healthy timing and spacing of pregnancy
IDI	In-depth interview
IEC	Information, education, and communication
IMC	International Medical Corps
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
MMR	Maternal mortality ratio
MOH	Ministry of Health
MRDA	Mundri Relief and Development Association
MSI	Management Systems International
MSH	Management Sciences for Health
MTH	Malakal Teaching Hospital
NBHS	National Baseline Household Survey
NGO	Non-governmental organization
OXFAM	Oxford Committee for Famine Relief
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PSI	Population Services International
RH	Reproductive health
RSS	Republic of South Sudan

SSP	South Sudan pounds
SHTP-II	Sudan Health Transformation Project, Phase II
SMOH	State Ministry of Health
SHHS	Sudan Household Health Survey (2010)
SSCCSE	Southern Sudan Centre for Census, Statistics & Evaluation
SSHHS	Southern Sudan Household Health Survey (2006)
STD/STI	Sexually transmitted disease/sexually transmitted infection
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNS	Upper Nile State
USAID	United States Agency for International Development
WBEG	Western Bahr el Ghazal
WES	Western Equatoria State
WHO	World Health Organization
WRC	Women's Refugee Commission

EXECUTIVE SUMMARY

OVERVIEW AND RATIONALE

Dying while giving birth is a far too frequent tragedy in South Sudan. For every 50 children born alive, roughly one mother dies during pregnancy or childbirth. Globally, it is well established that child spacing and family planning (FP) programs can prevent many women from dying needlessly in pregnancy and childbirth. Family planning and contraceptives were introduced in Southern Sudan as early as 1999 (see the Western Bahr el Ghazal report). With support from USAID, FP technical guidelines for health providers were developed in 2006, and a national FP policy was developed in November 2009. Still, use of modern contraception in South Sudan remains today among the lowest in the world, with an estimated prevalence of only 1.5% (or 3.5% if lactational amenorrhea method [LAM] is included). Why?

USAID/South Sudan and the Republic of South Sudan's Ministry of Health (MOH) commissioned this study to better understand the reasons for the low use of contraception in South Sudan. The ultimate aim is to help the government of newly independent South Sudan, assisted by USAID/South Sudan and other health development partners, to provide a package of reproductive health (RH) services that will reduce maternal and child mortality in the country. The MOH and USAID believe that understanding knowledge, attitudes and practice concerning FP is essential to reducing maternal and child mortality, as well as for designing effective FP activities.

To have results ready to feed into program decision-making in 2011, MOH and USAID agreed to use a rapid qualitative methodology for data collection. This consisted principally of key informant interviews, focus group discussions (FGDs) and in-depth interviews (IDI) during the month of August 2011. National representativeness was a priority for the study. Thus, the MOH specified that the research be conducted in three of the country's 10 states. The state-specific studies were carried out in Upper Nile State (UNS), Western Equatoria State (WES) and Western Bahr El Ghazal (WBEG) following pre-testing of the methodology in Juba. A team of three international consultants was contracted to lead the study. Working with the MOH and USAID/South Sudan, they brought together a team of 14 South Sudanese individuals to serve as data collectors and to participate in data analysis. Of these, seven were MOH employees while seven were independently hired.

MAJOR CONCLUSIONS AND RECOMMENDATIONS

1. Donors and the government should shift their focus and terminology from "family planning" to "child spacing."

To encourage use of modern contraceptive methods, proponents should use the terms "child spacing," "birth spacing" or "healthy timing and spacing of pregnancies" instead of "family planning." These recommended terms build on long-accepted practices.

"Family planning" is not an easily understood concept in much of South Sudan. Given the persisting cultural norm to marry young and produce as many children as possible, with polygamy remaining common, the idea of "planning a family" does not fit with any concept of life for the majority of people. Furthermore, it has acquired a negative reputation among the few who have heard of it. Many understand it to mean permanently terminating childbearing and many associate it with prostitution. A few respondents said FP means reducing the population and said "We already lost too many in the war."

Child spacing, in contrast, is a deeply-rooted and valued cultural norm about which people feel very positively. Traditionally, child spacing is achieved by two to three years' postpartum sexual abstention by the couple, often facilitated by the husband having more than one wife. People know it is important for health of the mother, health of the child, and even health of the family. The tradition includes the mother breastfeeding for two to three years, during which time it's believed that she should not become pregnant again or serious illness may befall the infant and even entire family. It is for this reason that the husband abstains from sex with her.

Today, young couples who cannot maintain three years of abstinence still seek to space their children at least two years apart. They maintain the belief that the child should breast-feed for two years and that danger may befall the child if the mother becomes pregnant while breastfeeding. Many couples are conflicted now because modern life makes three or even two years' sexual abstinence very difficult. This is where some women seek or start to use "modern drugs" (pills, injection or implant) to delay their next pregnancy—often in secret from their husbands. Many women fear that if their husbands knew they were using contraception they would be beaten as a consequence.

Best-practice experience from many other African countries in the "launch" stage of FP has been to promote child spacing in the context of family welfare programs.

2. Provide essential upgrading of all basic/primary health care and reproductive health (RH) services as a basis for provision of child-spacing services.

This includes upgrading and supplying equipment, training for greater provider competency, supplying of essential medicines, beds, labs and repairing facilities. This is essential for a maternal mortality reduction package. Without this upgrading, expanding safe and quality provision of child-spacing services will be difficult.

3. Increase the number of midwives quickly, especially community midwives.

The highest priority for reduction of maternal and child mortality, and for RH generally, is to increase the number of qualified midwives who have the basic equipment and medications. The plea (e.g., from Upper Nile) is to build a cadre of community midwives with 18 months of training who can provide a package of basic RH/maternal child health (MCH) services, including accurate information on contraception and child spacing. Without this, change and improvement will be extremely slow. Diploma midwives are desirable eventually, but take too long to be trained (three years) to meet current needs. Further, as diploma midwives prefer to work in the cities and urban hospitals, they are not likely to cover the needs of more rural areas.

4. Frame awareness messages to the public as "child spacing for family health and well-being" and not as "family planning."

Awareness messages (information, education and communication [IEC]) should be framed in the local language by native speakers. Awareness events and messaging should build on and appeal to local values, especially that of child spacing. To be accepted, messages must be in terms that are culturally sensitive and locally understandable.

5. Plan awareness events that appropriately engage husbands.

Appropriate male involvement is crucial, as men are the decision-makers in most aspects of life in South Sudan. The goal should be awareness activities among both men and women to expand knowledge, as well as to create acceptance among husbands that child spacing—part of South Sudanese tradition—is important for the health of both the mother and child. Child spacing should be promoted as an essential element of MCH or RH services. Religious and local community leaders should be involved in the events. Awareness must be accompanied by availability of supplies as well as improved counseling and monitoring of new contraceptive

users, so that users do not become confused or disillusioned and drop out. Supportive religious and other community leaders should be involved in these events.

6. Along with health, emphasize the economic difficulties of couples whose children are born too close together when promoting modern methods of contraception.

Poverty is severe. Many women struggle to access food for their children and families. Children are often sick, but most families cannot afford to pay for the treatment that they or the parents need. Some men and women are beginning to recognize the unfortunate link between having many children and economic difficulties. It is predominantly these individuals who are becoming more open to, and have even tried, contraception.

7. Integrate child spacing promotion with other maternal and child health interventions.

Child spacing should be promoted as an essential element of MCH and RH services, building on the established *cultural norms,* which are now reinforced by *modern science.*

8. Address the needs of young people—especially young women.

Many young unmarried people, especially those who are in school, need contraception. An RH advisor in the MOH in Juba summarized: "*There is urgent need to rethink the definition of family planning. Young women—single women over 18 who need contraception—should not be turned away. The main cause of death of young women is unsafe abortion*." This suggests that USAID and partners consider the approach that USAID defines as "healthy timing and spacing of pregnancy" (HTSP), which specifies that healthy timing for pregnancy begins after age 18.

9. Support the MOH in efficiently meeting people's urgent expectations of their new state government.

Local people's expectations for what their new government should do to help them are substantial. "*We are at a crossroads*," said one state official. "*We are now coming out from this war which has destroyed all infrastructure, everything. It is the time when our new government must help.*" Collaboration and effective communication channels between the Juba MOH and the state ministries of health (SMOHs) need to be developed. Donors can assist by planning interventions in ways that more directly involve not just the MOH in Juba, but the SMOHs.

10. Put research and recommendations into action.

State officials and some service providers lament that many assessments have been conducted in their areas during recent years, but with virtually no feedback in terms of improvements of the facilities and services investigated, nor even of report sharing. Most such assessments and visits took place before independence. Expectations are now high that the new government of the new South Sudan will respond to the already thoroughly identified local needs.

11. To focus on geographically remote and hard-to-reach areas is not practical at this time—and won't be until transportation to villages is improved.

Not only is demand extremely low in geographically remote areas, but getting information and services to remote areas is a major challenge and would be a drain on the nascent program. Many of the rural communities currently have little or no knowledge of contraception/FP and its benefits. The government and donors should build goodwill by improving the most basic health services in rural areas and increasing child survival that way. Until then, efforts to introduce modern contraception are likely to be met with hostility.

Instead, in the near term, programs should use a radial approach to increasing availability and use of modern child-spacing methods, saturating the state capital and peri-urban communities and moving outward as uptake increases and examples of success can be built upon.

12. Revise and update the Southern Sudan draft family planning policy.

The evidence from this study indicates that a revision of the Government of Southern Sudan's Draft Family Planning Policy (prepared in large part by consultants in November 2009) is in order. This document ignores the lessons learned globally during past decades when the best-practice approach to launching contraceptive use in many African countries has been birth spacing and family welfare.

13. Do not seek to reduce violence against women via family planning.

USAID has asked whether it is possible to decrease violence against women (VAW) by promoting FP. Findings from this study, and the global literature, suggest that the answer is "no" for South Sudan. This is often a good idea in countries where contraceptive use has reached a much higher level of acceptance (e.g., a contraceptive prevalence rate [CPR] above 20%). But in communities that are hostile to FP, as are many in South Sudan, it would be too hard to do successfully, and no measurable impact could be achieved.

Section III, Recommendations, contains somewhat more explanatory detail than this executive summary. A greater level of detail is found in a second set of reports, which contains four state reports with the team's detailed findings from Juba, Upper Nile, Western Bahr El Ghazal, and Western Equatoria. As these four state reports were outside the GH Tech Project's scope of work for this assignment, it was prepared as supplemental material to this overview report. An electronic version of the four state reports has been made available to USAID/Washington and USAID/South Sudan, and can be obtained upon e-mail request to USAID/South Sudan or the GH Tech Project.

I. INTRODUCTION

SOUTH SUDAN: STARTING A COUNTRY "FROM SCRATCH"

Following two civil wars and conflict that spanned 50 years and left two million dead, South Sudan finally gained its independence July 9, 2011; it is the newest of the world's countries.[1] With a jubilant victory and the promise of a better future, South Sudan aims to truly be what its new national anthem says: "Land of great abundance, uphold us united in peace and harmony." (See Appendix E, map of South Sudan.)

South Sudan has the potential of becoming a major agricultural producer for Africa. The country has fertile land and the Nile acts as the main source of water. However, the lack of further resources is a daunting hindrance to the country's future development. Historically, the country never experienced a strong colonial presence, unlike its neighbors Uganda and Kenya, and thus finds itself with virtually no infrastructure. It has one of the least-developed economies in the world, due in great part to traditional neglect by the Sudanese central government and to devastation wrought by the civil war (1955-2005), during which physical infrastructure, human resources, and social services suffered. Infrastructure in electricity, water and sanitation, roads, transportation, and information and communication technologies remains poor. Slightly smaller than France or the U.S. state of Texas, South Sudan has no railroads and is said to have fewer than 100 kilometers (about 66 miles) of paved roads. (No paved roads connect Juba, the capital, with the next largest cities, Malakal and Wau.) Households have few assets and little or no access to markets. Largely a cash economy, there is no banking system that connects the public with external resources, no ATMs that connect between banks, and no acceptance of credit cards. In August, South Sudan was just beginning to shift from the old Sudanese currency to its own newly issued South Sudan pounds (SSP). An effective medical system does not exist. Many universities have been closed for some time, although some are struggling to re-open. During the study period, government ministry offices were in flux.

HEALTH AND DEVELOPMENT CHALLENGES IN SOUTH SUDAN

The government's *Maternal, Neonatal and Reproductive Health Strategy 2009–2015* begins with the following somber summary:

> *"For decades Southern Sudan was involved in an unrelenting war which led to poverty, deprivation, under-development and ill health. All health indicators including infant and under-five mortality, fertility, crude birth, and maternal mortality indices are among the worst in the world. Indeed, we have the unenviable record of having the highest maternal mortality ratio in the whole world. With the signing of the Comprehensive Peace Agreement (CPA) in 2005, there should however be real hope and opportunity for development and progress in all sectors of life including health. With our poor status of maternal, neonatal and reproductive health, it stands to reason that the emphasis for an accelerated development of the health sector in the new dispensation should be on reproductive health."*[2]

[1] Roughly 2 million people died as a result of war, famine and disease caused by the five decades of civil war and conflict. Four million people in South Sudan were displaced at least once, and often repeatedly, during the war. The conflict officially ended with the signing of the Comprehensive Peace Agreement in January 2005. There are still occasional conflicts and insecurity, particularly in some parts of South Sudan that border north Sudan.

[2] GOSS, Ministry of Health. "Maternal, Neonatal and Reproductive Health Strategy 2009–2015." p. vi.

The maternal mortality ratio (MMR) of South Sudan is officially stated as 2,054 per 100,000 live births.[3] This means that, in South Sudan, approximately 1 woman dies for every 50 pregnancies that result in a live birth. About 230 South Sudanese women die in pregnancy and childbirth for every 1 woman in developed countries. As compared to other developing countries, about four times as many South Sudanese women die in pregnancy and childbirth.[4]

Population Characteristics (figures approximate)[5]

- Multiethnic, multicultural, and multilingual, consisting of more than 60 indigenous ethnic communities with diverse cultures.
- Total population about 10 million in 10 states, having increased significantly with independence, due to the return of refugees and internally-displaced people.
- High fertility rate (6.7 per woman) and high rates of teenage pregnancy. It is customary for many girls to be married at 14 or 15 years, so "teen pregnancies" do not all equate to teens being unmarried.
- Widespread poverty. Approximately half the population lives below the official poverty line.
  - Poverty in rural areas is double the ratio in urban areas (based on headcount ratios).
  - Poverty rates vary significantly between states.
- A young population: 72% of the population is under 30 years of age and 51% of population is under 18 (2008 census)
- Low literacy. Fewer than 14% of women aged 15–49 years are able to read and write vs. about 36% of men (2010 SHHS).
- The working population are mainly subsistence farmers, pastoralists, fishermen, and business people, including petty traders.
- The general economy is weak and largely dependent on donor in-flows and oil revenues.

BACKGROUND AND PURPOSE OF THIS STUDY

Reducing maternal mortality is among the highest priorities for the South Sudan Health Sector Development Plan 2011-2015.

Globally, use of modern contraception for child spacing and family planning services is directly associated with reducing maternal mortality. In South Sudan, however, use of modern contraception is among the lowest in the world, with estimated prevalence of only 1.5% or 3.5% when including LAM. Related to these facts, USAID/South Sudan and the Republic of South Sudan (RSS) Ministry of Health have commissioned this study to better understand the reasons for the low acceptance of modern contraception in South Sudan and, accordingly, to facilitate design of services that respond to needs and preferences of the South Sudanese people.

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[3] Southern Sudan Household Health Survey (SHHS 2006), cited: GOSS, Ministry of Health. "National Reproductive Health Policy." May 2011, p.12. "Maternal, Neonatal and Reproductive Health Strategy 2009–2015," p. 8.

[4] According to WHO, the average maternal mortality ratio (MMR) in developing countries is 450 maternal deaths per 100,000 live births vs. 9 in developed countries.
See: http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/

[5] The Government of Southern Sudan, with support from development partners, carried out a large *National Baseline Household Survey* (NBHS) in 2009. This is considered representative for South Sudan, its 10 states, and its urban and rural areas. Data here derive from the NBHS.

The specific purposes of the study have been:

1. To obtain qualitative information that will improve understanding of knowledge, attitudes, and practices about fertility, birth spacing and limiting, and FP and RH services.
2. To support the RSS MOH, health development partners, UN agencies, and health implementing partners in developing evidence-based strategies, policies, and programs to effectively scale up family planning and RH activities and services that respond to the preferences, needs, and priorities of its key target audiences.
3. To identify and recommend potential mechanisms to engage local government and community support for family planning and birth spacing.

An additional purpose was to contribute to capacity building of MOH personnel in conducting qualitative research, including developing and field testing study instruments and data collection and analysis. The study did achieve this objective. Seven MOH employees participated in the training. Of these, five also took part in the field research, which was intensive hands-on capacity building.

METHODOLOGY

National representativeness was a priority for the study. To represent the three major regions of South Sudan, the MOH decided that the study should be conducted in the following states: Upper Nile (UNS), Western Bahr el Ghazal (WBEG) and Western Equatoria (WES).

Languages spoken in the three states:

Upper Nile: English, Classical Arabic, Dinka, Nuer, Shilluk and Maban.

Western Bahr el Ghazal: English, Crach, Classical Arabic, Balanda and Jur Chol.

Western Equatoria: English, local Arabic and Moru.

In order to have results ready to feed into program decision-making in 2011, MOH and USAID agreed to use a rapid qualitative methodology. This consisted chiefly of key informant interviews, in-depth interviews (IDI) and focus group discussions (FGDs).

A team of three international consultants was contracted to lead the study. Working with the MOH and USAID, they brought together a team of 14 South Sudanese individuals to serve as data collectors and participate in data analysis. Of these, seven were MOH employees and seven were independently hired for the study. None had been formally trained as researchers; this presented many challenges.

Language

With so many languages in the country, the team made great effort to construct the study so that interviews could be done in the local languages. Language competency for the three states was thus an important goal in recruiting of data collectors (but hard to meet).

Training

A five-day training workshop for the data collectors took place 8–12 August in Juba.[6] Objectives of the workshop were as follows:

1. To organize and prepare three teams of data collectors, coordinators and MOH quality assurance staff who would work together to collect and analyze data for this study.
2. To discuss and clarify the key elements of the RAPID research methodology (a fast method of conducting qualitative assessments).
3. To pre-test the core set of data collection guides developed for this study, make needed modifications, and translate key guides into local Arabic.

Data Collection Guides

The core set of guides developed for this study were:

- Focus group discussion guides (three): one for women (translated into Arabic); one for men; and one for service providers.
- In-depth interview guides for community members (four): one for women; one for men; one for village leaders; and one for service providers.

Modification of the Guides

The study had been titled and planned as a "Family Planning Demand Study." The international consultants had drafted a core set of guides for the IDIs and FGDs, based on their review of the relevant South Sudan literature and their familiarity with African countries launching family planning programs. The pre-testing of the guides in Juba confirmed that "demand for family planning" is extremely low. The guides were consequently modified to place more emphasis on child spacing.

Advance Reconnaissance Visits

One local data collector (part of the 14-person team) made a preparatory trip to two of the states, UNS and WBEG. The main purposes were (1) to inform officials about the study and its objectives; and (2) to make arrangements for FGDs and interviews. This was beneficial in orienting government and non-governmental organization (NGO) leaders in advance.

[6] The workshop was designed and led by Dr. Soheir Stolba, training specialist, one of the three international consultants leading this study. Details of logistics and methodology are presented in her report, "Child Spacing and Family Planning in South Sudan: Knowledge, Attitudes and Practices: Training Report." October 2011.

Fieldwork

The three teams spent two weeks working in the field (August 14–26), each team in one of the three states. Teams had some support from local government and NGOs in arranging for data collection (IDIs and FGDs). However, given the extremely challenging constraints (especially the difficulty of communication and transport), it was not possible to arrange data collection events in advance. Each team needed to be very resourceful in arranging these events and achieving the desired balance in interviewees among male/female, younger/older, urban/rural, educated/non-educated and ethnic participants. Interviews typically lasted 30 minutes to an hour while FGDs averaged about two hours. Information collected was carefully recorded on the corresponding IDI and FGD guides. Each evening the teams met to review and assess the day's experience and plan for the coming day.

Data Analysis

During the following week, from August 29–September 2, the teams met back in Juba; they organized and tallied the data collected (using the information recorded on the IDI and FGD guides) and drafted a preliminary short report for each state. Guided by Dr. Barbara Pillsbury, the seven data collectors hired by the study performed this work. (All MOH team members were required by the MOH to return to their posts.) The three international consultants, back in the U.S., subsequently spent weeks in detailed analysis and report writing.

Table 1. Data Collection Summary: All States

State	Total Respondents (women and men)	# In-Depth Interviews	# Focus Group Discussions
Upper Nile	184	64	16
Western Bahr el Ghazal	229	78	16
Western Equatoria	269	77	19
Juba	42	22	3
TOTAL	724	241	54

UPPER NILE STATE: OVERVIEW AND FIELDWORK

Upper Nile State has a population estimated at about one million—although statistics for the state are not yet known or readily available. Looking at a map, UNS appears to sit on top of South Sudan, projecting up into Sudan. It shares a longer border with Sudan than with South Sudan, and its culture is heavily influenced by that of the north. Arabic is the lingua franca. The three states Upper Nile, Unity and Jonglei constitute the region Greater Upper Nile.

Malakal, the capital of the state and of Malakal County, has a population estimated at slightly less than 140,000 (2010). The population has increased with displaced persons and returnees coming back from Khartoum in 2010–2011, especially following independence. Malakal lies approximately 650 kilometers (400 miles) by unpaved road directly north of Juba. Malakal itself has no paved roads. The long rainy season renders the poor roads impassable—isolating communities and limiting mobility and trade. Trade has also declined with the post-independence embargo by Sudan, formerly a chief source of trade, food and other goods for the state. This has caused severe escalation of prices in the market, with a sharp increase in the overall of living.

The main ethnicities are the Dinka, Nuer, and Shilluk (Shilluk: *Chollo*), all of whom are considered Nilotic peoples and speak Nilotic languages. The terms *Nilotic* and *Nilote* are used to distinguish them from their ethnic neighbors, mainly Bantu-speaking people. Nilotic people constitute a large part of the population of South Sudan. The single largest ethnicity in South Sudan is the Dinka, which includes as many as 25 ethnic subgroups. Next largest are the Nuer, followed by the Shilluk.

Like most Nilotic groups, cattle-raising forms a large part of their economy, complemented by agriculture and fishing. Most Dinka, Nuer, and Shilluk have converted to Christianity, while some still follow the traditional religion or a mixture of the two. Small numbers have converted to Islam. Most respondents in this study said they are Christian.

There is substantial ethnic mixing, including intermarriage, at least in Malakal. In Malakal, the Dinka, Nuer, and Shilluk live interspersed; there are no communities (*payams* or *bomas*) that are wholly Dinka, Nuer, or Shilluk. Intermarriage is common. In contrast, some nearby villages are populated primarily by one ethnic group (e.g., Wau Shilluk by Shilluk, Bintiang by Dinka, and Obel predominantly by Nuer, but with many Shilluk).

Cattle are a primary currency among the Nilotic peoples. Many aspects of life are oriented around the family cows. Cows represent wealth and social status, and are used for compensation of wrongdoing and payment of dowries. Raiding or rustling—the theft of cattle from neighboring owners or tribes, often to replenish stocks—is common. Cattle raiding and associated conflicts have been a part of agro-pastoralist life for generations.[7]

Fieldwork in Upper Nile State

Data collection took place in two counties: Malakal and Panyikang.

Participants in the FGDs and IDIs ranged from illiterate villagers (in Wau Shilluk and Obel villages on the Nile) to university graduates. (Among seven men in the FGD at the Ministry of Irrigation, six were university graduates.)

The four-person team was based in Malakal, capital of UNS. Much of the first week was consumed in securing an official letter and permits in order to facilitate interviews and allow for travel to rural villages outside Malakal. A second challenge was communication and transportation; with no paved roads in Malakal, the deep mud of the rainy season was a great impediment to meeting and conducting the necessary interviews. [8] This was complicated by unreliable mobile phone connectivity.

Language was a third major challenge. Government officials spoke English, Arabic, and their native languages, while community members spoke Dinka, Nuer, Shilluk, or Arabic. The team comprised a native Dinka speaker and Arabic speakers, but it was necessary to recruit translation assistance for Nuer and Shilluk. This language challenge meant that it was not always possible to achieve the desired gender composition for IDIs and FGDs (e.g., only female team members and translators were able to conduct IDIs and FGDs with women).

[7] The estimated 12 million cattle and 25 million goats and sheep of South Sudan, while of value to their owners as assets, do not add any revenue to the country because they are seldom sold.
[8] The rainy season lasts five to six months in the north. During the rainy season, research is significantly obstructed by deep, slippery mud, taking three to four times as long as if during the dry season.

Nevertheless, the team persisted. In addition to IDIs and FGDs in Malakal and peri-urban communities, the team traveled by Nile wooden speedboat to two villages.[9] First was Wau Shilluk, a Shilluk village across the Nile in Malakal county, a half-hour north of Malakal by boat, where the International Medical Corps (IMC) was supporting a primary health care unit (PHCU). Second was Obel village, a predominantly Nuer village (with some Shilluk), an hour south of Malakal in Panyikang county. Plans to visit a Dinka village, Bintiang, had to be cancelled due to a combination of security threats and the rapidly escalating cost of gasoline.[10]

The team succeeded in conducting 16 FGDs and 64 IDIs. Taken together, participants included 110 women and 74 men. Exact details are presented in Table 2. This represented a good balance of:

- Women vs. men (women of reproductive age; men of any age, but married to women of reproductive age)
- Older women (30–49) vs. younger women (18–29)
- Urban residents and workers, peri-urban residents, and isolated villagers;
- Respondents with no schooling vs. with formal education (primary to university)
- Illiterate vs. literate
- Members of the three ethnicities/tribes: Dinka, Nuer, Shilluk
- Village and religious leaders

[9] These village visits were kindly facilitated by the Malakal office of the International Medical Corps (IMC), implementing partner in Upper Nile State of the USAID-sponsored SHTP-II. Other data-gathering was facilitated by the Reproductive Health Advisor of American Rescue Committee (ARC) in Upper Nile State, Mr. Joseph Duop.

[10] When the team began planning the village visits, gasoline sold in the market for 25 SSP per liter. Within a few hours it had gone up to 40 SSP per liter. Three days later, when the team hoped to go to Bintiang, it had shot up to 55 SSP per liter. This illustrates the escalating market costs, which respondents bemoaned.

Table 2: Data Collection Summary, Upper Nile State					
	Urban	Peri-urban	Rural	Total FGDs	Total persons
Focus Group Discussions					
Women: younger, lower parity (generally 18–29)	1	1	2	4	31 women
Women: older, higher parity (generally 30–49)	1 (Dinka)	1	2 (Nuer)	4	35 women
Women total FGDs: 8					
Men married to women of reproductive age	1 (Dinka relig. ldrs); 1 Min of Irrig		1 (Shilluk); 1 Nuer & Shilluk	4	30 men
Health providers and managers	1 Nurses; 1 IMC	1 CBD		3	11 women 9 men
Religious leaders	4			1	4 men
Total FGDs = 16 (8 women's; 4 men's; 3 providers; 1 relig.leaders)	6	3	6	16	77 women 43 men
In-depth Interviews					
Key informant interviews: RSS government	4				4 men
Women: younger, lower parity (generally 18-29)	9	10	--		19 women
Women: older, higher parity (generally 30-49)	2	6	--		8 women
Men: younger	1	2	2		5 men
Men: older	6	2	1		9 men
Sub-total IDIs	22	20	3		27 women 18 men
Community leaders/influential persons:					
Traditional chiefs and village elders (male)		1	2		3 men
Health care providers:					
Public sector (5 female, 3 male; includes 2 UNFPA contract midwives, 1 TBA)	6		2		5 women 3 men
NGO (1 male, 1 female)	2				1 women 1 man
Private practice providers					--
Pharmacies (short visits)	6				6 men
Total IDIs = 64	36	21	7		110 women 74 men

WESTERN BAHR EL GHAZAL: OVERVIEW AND FIELDWORK

Western Bahr el Ghazal is the least populous state in South Sudan, according to the 2008 census. Wau, the capital and seat of Wau County, lies on the bank of the Jur River, approximately 650 kilometers (400 miles), northwest of Juba. Most of the state's population is concentrated around Wau, leaving the rest of the state sparsely inhabited (see map in Appendix E). In 2008, Wau was the third largest city in South Sudan, by population, after Juba and Malakal. Now in 2011, its population is estimated at about 151,000. Wau is a culturally, ethnically, and linguistically diverse urban center. Local ethnic groups include the Balanda Boor, Balanda Bviri (Balanda Viri, Balanda Bagari), the Jur Luo, Ndogo, Kresh, Bai, Baggara Arabs, and many others. During Second Sudanese Civil War, it was a garrison town of the Khartoum-based Sudanese Armed Forces and the scene of extensive fighting in 1998 and 2007.

Fieldwork in Western Bahr el Ghazal State

The five-person, all-female team was based in Wau. Data collection took place in two counties: Wau County and Jur River County. One team member lives in Wau and facilitated most of the FGDs in Arabic. One team member had to return to Juba after the first week due to the death of her father.

While challenging, the work was greatly facilitated by the active cooperation of the SMOH, the County Health Department (CHD), John Snow, Inc. (JSI), and Red Cross of South Sudan. These organizations provided contacts, made some appointments, and arranged for the research team to meet with several communities. The research team briefed the State Minister of Health on the scope and purpose of the study.

Research began in Wau, where the team interviewed women of childbearing age, men married to women of childbearing age, and service providers including the SMOH Director General, Wau Teaching Hospital Director General and Medical Director, Wau CHD staff, NGO and development partner staff, and health visitors (senior nurse-midwives). The team also conducted focus groups with men, women, and midwives in Wau. Since Raja County was too far to access, but has a coordination office in Wau, team members interviewed two men from that office.

In addition to conducting interviews and FGDs in Wau town, the team traveled to two *payams* in Wau County and four in Jur River County. In Wau County, the team went to Bussere and Angisa, 25 and 45 minutes from Wau town, respectively. Both have health facilities supported by JSI as part of USAID's Sudan Health Transformation Project, Phase II (SHTP-II). Just 18 kilometers (12 miles) south of Wau, Bussere can be considered peri-urban and is the only peri-urban site visited. It has a recently built and fairly well-equipped primary health care center (PHCC), two Catholic seminaries, a market, and an ethnically diverse population (mostly Bongo, but also Balanda, Luo, Dinka. Angisa, primarily Balanda, has a much smaller and older PHCU, located near the *payam* center and one-room school. The closest Jur River *payam* visited was Marial Ajit, about 45 minutes from Wau town. Mariel Ajit is primarily Dinka and has a PHCU. (One man there loudly objected to and nearly impeded the research, but the situation was defused and the work proceeded.) Abou is an hour outside Wau, primarily Luo, and has an unstaffed health facility. Health staff from the closest PHCU, in Gette, were interviewed. Kangi *payam* was the furthest—about 80 minutes drive from Wau and primarily Dinka. Kangi has a PHCU; most respondents were Luo, but there were also a few Jur and Dinka respondents.

Most of the interviews and FGDs were conducted in Arabic, with notes taken in English. The principal investigator conducted interviews in English, using interpreters in Angisa and Gette. Otherwise, language was only a challenge in Jur River County, where the team used interpreters from the community (Red Cross volunteer community facilitators), health facility, SMOH, and Red Cross.

The team conducted FGDs and interviews with a total of 122 persons. The table below shows the number and type of FGDs and interviews conducted.

Table 3: Data Collection Summary, Western Bahr el Ghazal State				
Type/Group	Urban	Peri-Urban	Rural	Total
Focus Group Discussions				
Women of reproductive age (80 participants)	2	1	5	8
Men married to women of reproductive age (41 participants)	1	1	3	5
Health Care Providers (23 participants)	3*			3
Total FGDs	6	2	8	16
In-depth Interviews				
Key informant interviews: RSS Government (MOH/Wau Teaching Hospital), SMOH, CHD, Raja County Coordination Office	7			7
Women: younger, lower parity (0–4 children, generally 18–29)	10	2	4	16
Women: older, higher parity (5 or more children, generally 30–49)	2	1	4	7
Men married to women of reproductive age	4	5	14	23
Single men				
Community leaders/influential persons:				
Traditional Leaders	1	1	3	5
Religious Leaders			2	2
Mothers in-Law		1	4	5
Health Care Providers and Managers				
Public sector	3	1	1	5
CHWs/CHVs			4	4
Partners/NGOs	3			3
Faith-based	1			1
TBAs			1	1
OTHER				
Pharmacy Staff (brief interviews)	6			6
Total number interviewed	37	11	37	85

*3 FGDs were held in Wau with midwives attending a workshop from urban, rural, and peri-urban facilities.

WESTERN EQUATORIA: OVERVIEW AND FIELDWORK

Western Equatoria, along with the states of Eastern Equatoria and Central Equatoria (where Juba is located) comprise the Equatoria Region of South Sudan (see map above). The areas are known for their fertile land and availability of water and Central Equatoria has the Nile River.

Other areas in the west are not as lucky. Water is procured from boreholes, which tend to dry up in the dry season and thus makes the availability of water a survival issue for much of the population. Most study respondents complained of water shortages and the high cost of water. The population of Western Equatoria was estimated in the 2008 census at 619,029.

There are vast distances between population settlements, which are barely connected by unpaved roads, some of which still have land mines—making travel especially dangerous. Transportation was a top issue that people complained about in both FGDs and individual IDIs. There are no bridges in Mundri East and the cost of transportation is very high for people with modest incomes. The recent rise in gasoline prices and the lack of availability of fuel caused several delays for the research team.

Generally, markets are far from most homesteads, the nearest community being approximately 10 kilometers (6 miles) to Kediba market, except for small nearby homesteads. The biggest markets are those of Mundri and Lui. Thus, people must pay for expensive transportation to reach the market.

Most people depend on subsistence agriculture. The population grows sorghum, cassava, groundnuts, beans, maize, pumpkin, sweet potatoes and tomatoes. Unemployment figures for Mundri West and East are not available. However, respondents complained that a large number of people are unemployed. Men often migrate to Juba to seek employment.

The people of Mundri East consider themselves to be conservative. Part of this conservatism is reflected in their rejection of contraceptives and new technologies.

Mundri West has an excellent local non-profit organization, the Mundri Relief and Development Association (MRDA), which is a partner in USAID's SHTP-II. Several respondents praised MRDA's efforts to provide effective health services, including immunizations for children and much needed services to women, including FP. According to the health care providers interviewed, MRDA began its FP services in 2010, as did the international NGO, Population Services International (PSI). Family Health International (FHI) launched an HIV/AIDS awareness, counseling and testing project in Mundri in approximately early 2011.

Fieldwork in Western Equatoria

The study team collected data from East Mundri County and West Mundri County (population 48,318 and 33,975, respectively).[11]

A team of five data collectors traveled to East and West Mundri by car. All five are South Sudanese. Unlike the other two teams, this team worked without the on-site guidance of an international consultant. Dr. Soheir Stolba, the principal investigator with this team, left for the U.S. after completing the training workshop. She maintained a close relationship and communicated with the team via email during the fieldwork as well as during data analysis. Dr. Stolba subsequently drafted the state report based on the data collected.

The team experienced difficulties because of the poor and dangerous (due to land mines) road conditions and the inflated price of gasoline. In East Mundri County, the research team traveled to Kediba, Wandi, Dosho, Kediba *Payam*, Lui, Lanyi, Lozoh *Payam* , and Mideh (Wittoh *Payam*). In West Mundri County the team traveled to Mundri (Mundri *Payam*), Amadi (Amadi *Payam*) and Kotobi (Kotobi *Payam*).

The team conducted IDIs and FGDs with men, women, health care providers, community health workers (CHWs), and village leaders. The researchers used a random sample of 228 men and

[11] USAID intends to fund agricultural projects in Mundri East and West; having information on FP from both counties was deemed useful.

women from both Mundri East and West. In-depth interviews were conducted with 30 women of childbearing age and 24 men. The rest of the sample included health care providers and managers, CHWs and village leaders. The total number of respondents was 269 individuals (see tables 3, 4, and 5).

Table 4: Study Population of Male and Female Respondents, Western Equatoria

Location	Sex	Number of Participants
Mundri West	Men	5 in-depth interviews
Mundri West	Men	30 focus group participants
Mundri East	Men	18 in-depth interviews
Mundri East	Men	33 focus group participants
		Subtotal: 87 men
Mundri East	women	16 in-depth interviews
Mundri East	women	57 focus group participants
Mundri West	women	14 in-depth interviews
Mundri West	women	54 focus group participants
		Subtotal: 141 women
		Overall total: 228 men and women

In terms of ethnicity, about 90% of participants were Moru, with a small number of Madi women and Mabon men. Among the three health care providers, one each represented the Fulani, Kuku, and Lotogo ethnicities.

Table 5: Study Sample of Health Care Providers, Managers, Community Health Workers and Leaders

Location	Job	No. of Respondents
Mundri East	Health Care Providers and Managers	9
Mundri West	Health Care Providers and Managers	7
		Total:16
Mundri East	Community Health Workers	14
Mundri West	Community Health Workers	6
		Total: 20
Mundri East	Village Leaders	1
Mundri West	Village Leaders	4
		Total:5
		Overall Total: 41

Table 6: Focus Group Discussions and In depth Interviews, Western Equatoria	
Focus Group Discussions	No. of Respondents
Men married to women of childbearing age	6
Women of childbearing age	10
Community health workers	3
In-Depth Interviews	
Men	25
Women of childbearing age	30
Village leaders	6
Service providers and managers	16

JUBA

In addition to the three designated states, FGDs and IDIs were also conducted in Juba. This took place August 10–11, for purposes of pre-testing the draft guides developed for the research. A total of 42 persons participated, many of them fairly recent arrivals to Juba from elsewhere.

Table 7: Juba: FGDs, IDIs and Respondents			
Method	# women	# men	Total persons
Focus group discussions (3)			
With women of childbearing age (2)	6 and 11		
With men		3	
In-depth interviews			
With women of childbearing age	8		
With men		14	
Total	25	17	42

FEEDBACK FROM STUDY PARTICIPANTS

In most cases, participants took the experience seriously. Some were positive. At the end of the interview, data collectors asked "Is there anything else you would like to tell us related to what we have discussed?" One response, from a Nuer farmer with six children, is illustrative: *"All things we discussed are important because I have never shared any problems and experiences with anyone before."* Although the study did not purposively dispense contraceptive information, many respondents felt this had been an important "awareness" experience. Many said it was the first time they had ever discussed matters of modern contraception and said they would like to learn more. As one village chief (sultan) in Upper Nile expressed, this was the first time anyone had come to his village to talk about health issues and he welcomed more "*to do awareness to both men and women like you are doing… Organizations should come and study the views of the community and take those views to the government.*" It is clear that participation in the FGDs and interviews

caused many respondents to begin to think differently and more positively about modern child-spacing methods.

The study methodology has opened a space for the respondents to be heard and to experience an opportunity to have their concerns noted and shared with the government, notably the MOH and SMOHs. (For this reason, it is important that the four state reports be shared with the SMOHs.) Study results reinforce the view that the need for community dialogue on issues of child spacing (and FP for some) is urgent. While there is a perception that people in this post-conflict environment do not want to hear about FP, many definitely want help with child spacing (and even a small few have interest in contraception for other purposes).

THE SIX REPORTS

This report is one of six derived from this study. The six reports are the following:

1. *Child Spacing & Family Planning in South Sudan: Knowledge, Attitudes, Practices and Unmet Need (**Overview**)* by Barbara L.K. Pillsbury (the current report)
2. *Child Spacing & Family Planning in South Sudan: Knowledge, Attitudes and Practices: **Training Report*** by Soheir Stolba (internal USAID document)

The above two reports are accompanied by four state-specific reports in addition to this main overview report.

1. *Child Spacing & Family Planning in **Upper Nile State,** South Sudan: Knowledge, Attitudes, Practices and Unmet Need* by Barbara L.K. Pillsbury, Joel Daud Jubara Tombe, Elijah Bol Alier, and Vivian Konga
2. *Child Spacing & Family Planning in **Western Equatoria State**, South Sudan: Knowledge, Attitudes, Practices and Unmet Need* by Soheir Stolba, Leju Benjamin Modi, Valeriano Lagu Perino, Kareo Consolate, Amadrio Doreen Drani, and Mary Rose
3. *Demand and Unmet Need for Child Spacing (and Family Planning) in **Western Bahr El Ghazal State**, South Sudan* by Carol Hooks, Lona Elia, Atim Edisha, Eva John Ramadan, and Sunday Imunu
4. *Child Spacing & Family Planning in **Juba**, South Sudan: Findings Compiled from Pre-Testing of the Research Guides* by Soheir Stolba

A second set of this report contains four state reports with the team's detailed findings from Juba, Upper Nile, Western Bahr El Ghazal, and Western Equatoria, as noted above. Given that the four state reports were outside the GH Tech Project's scope of work for this assignment, it was prepared as supplemental material to this overview report. An electronic version of the four state reports has been made available to USAID/Washington and USAID/South Sudan, and can be obtained upon e-mail request to USAID/South Sudan or the GH Tech Project.

II. FINDINGS

Bringing together the findings from the states is useful for countrywide understanding. At the same time, this inevitably risks generalization. Planners are thus urged to read the country-specific reports as well.

MARRIAGE AND CHILDBIRTH

Traditional Marriage Patterns Shared by the Majority of the Population

The different ethnic groups and rural and urban dwellers represented in this study have similar traditions regarding marriage and childbirth. Among all, the purpose of marriage is viewed to produce children, preferably many, for the husband and his family. A 2004 study concluded:

> Within southern Sudanese society the role and status of women is a reflection of a culture that places a premium on the cohesion and strength of the family as a basis of society. The male is the undisputed head of the family and marriage as means of strengthening the bonds between families and clans within tribes. The role of women in this social pattern is that of cementing family ties through 'bride-wealth' [bride-price] and of producing children. To the outside observer, particularly one whose culture is based upon the rights of the individual, the status of women in southern Sudan is that of property.[12]

These are cultural norms that have evolved over countless generations and survived decades of war. They will not be significantly changed by a short-term donor project.

Age of Marriage

Girls marry young, with most married by 18; many marry as young as 14 or 15 and some as young as 12. The exceptions are the minority in urban areas or those pursuing higher education. It is common for girls to withdraw from primary school in order to get married. Boys marry slightly older, commonly between the ages of 16 and 22, although some men marry quite a bit older—up to age 30 it is said—because the father may need more time to acquire enough cows to pay a bride price.

Bride price is the price that a future husband's family must pay to the girl's family in order for marriage to take place. This is paid in cattle, traditionally a family's most valued asset and the measure of its wealth and status. Many view the bride price as payment for the addition of children to the man's family. In some cases, the bride price may be paid in installments. Some said goats and increasingly cash are accepted as part of the bride price.

Many girls are pregnant when they marry. In Western Equatoria, this was found common among urban populations in places like Mundri West, which is more urban, compared to Mundri East. During data collection, several women indicated that they were unmarried but had children.[13]

Deciding on a Marriage Partner

In the past, parents played a more influential role in selecting a marriage partner for their children. Today, it is more common for young people to decide themselves. Discussions about marriage often start during the couple's courtship. Then, the girl brings the proposed husband

[12] See Jok et al., 2004, section 2.4.

[13] Very few, if any, of the hundreds of women interviewed or who participated in FGDs said they wished they could have prevented pregnancies that resulted in the children they now have. For more detail, see Section II, Prevention of Pregnancy and Unwanted Births.

home for her parents' approval and the boy does likewise. If both sets of parents agree, the two can marry. If parents resist, a young woman may get pregnant as a means of forcing her parents to allow her to marry her boyfriend (the husband's family must pay the bride price). Among the Dinka and in general, the boy's father still plays a key role in selecting his sons' brides because he is the one to pay the cows.

Polygamy

One man having two or more wives is common, especially in rural areas. An obvious reason for taking more wives is to produce more children. The widespread conversion to Christianity appears to have little impact on this practice. In the words of one respondent: "*Religious leaders say only one wife, but people do not pay attention*."

The study asked men "What is the ideal number of wives?" More educated and more urban men tended to answer "one," while many less educated and rural men prefer two. The number of wives among married respondents in Upper Nile ranged from 1 wife to a village chief with 6 wives and 19 children. While many men have three or four wives, this is less common.

> "Generally speaking, men in Wau County (urban, peri-urban, and rural) wanted one or two wives. They expressed that having one wife was easier to manage but that having two meant that while one was pregnant or breastfeeding, the other could attend to the man and help in other ways. A few urban and peri-urban dwellers said men should have many wives, largely to have many children. In the more rural Jur River county, both men and women respondents preferred many wives and children. Reasons given for having many wives include: *being seen as brave and responsible, making the family large and famous,* and *to produce enough children to replace the cows paid for the wives*. Said one man in Kangi, *'To have many wives you must spend a lot of cows, but if those wives bring many girls, they replace the cows*.'...In rural areas, numbers of co-wives range as high as 10 or more, and some rural women encourage their husbands to take more wives (so they can rest from having children)." (From the Western Bahr el Ghazal report.)

The First Pregnancy

The new wife is expected to become pregnant as soon as possible after marriage. This makes for many "teenage pregnancies" among *married* girls. If the girl/woman does not become pregnant soon after marriage, community members believe she is probably infertile, and the husband's family often begins criticizing the woman.

> "If the female doesn't get pregnant for two to three years, parents from both sides, other relatives and friends of the man advise the couple to try other partners. Or the parents of the man may start to consult the elders as to why the wife is not conceiving. Some communities organize prayer sessions for the woman. Advising couples to try other partners is common in rural areas where most people are not educated. However, in the urban areas and among the educated, this practice is rare." (From the Western Equatoria report.)

> In rural Jur River County: "Many male respondents said they would send the wife back to her family if she failed to get pregnant within the first six months. Some would first have her examined by a doctor or traditional healer. If there was a problem, he would take another wife and the "barren" one could stay if she wanted or leave if she wanted. Meanwhile in Wau County [more urban] most respondents said it is up to couples to decide on when to have their first pregnancy." (From the Western Bahr el Ghazal report.)

While most rural people believe failure to conceive lies wholly with the woman, some urban couples think the man may also be to blame and will consult a doctor to determine this.

"Ideal Family Size" and Children Desired

This study did not find an "ideal family size" and this concept was not understood by interviewees. More dominant—and overwhelming any attempt to discuss an ideal family size—is men's desire to have "as many children as possible" or at least "as many as God can give." That, along with the number of wives a man can afford, and for some what the economy allows, determines family size.

Few men interviewed wanted fewer than four children. In WBEG, Dinka and Luo men and women were adamant about the need and desire for many children for reasons that include: dowry, care for cows, gain fame, protect from fights, experience joy from many children, cultivate land, care for elderly parents, make up for high child mortality, and remind them of deceased family members. One Luo man said he wanted 10 wives with 15 children from each of them. Many respondents (from all backgrounds of ethnicity, religion, gender, age, urban/rural) said the number of children is up to God and that children are a gift.

In Mundri, of the 25 men interviewed, 8 said they wanted only 1 wife, while 2 said they wanted 3 wives; and the rest could not determine how many wives they wanted. Of the same group, 18 men said they wanted 6 to 10 children; 1 man said he wanted 30 children; and 3 men said they wanted 4 children. The rest either said they didn't know the number of children they want or that it's "*up to God*." Most rural women wanted several children or *"as many as God can give me."* One woman said it is the man who decides, while another simply said she had no choice.

This also explains why most people interviewed do not understand the concept of "family planning." Said several respondents: *"A family is not something to plan. It is God who decides."* [14]

Are These Traditional Norms Changing?

The norms described above remain quite constant, including age of marriage. One major change is in *who selects the marriage partner*. Increasingly, it is the young people themselves. Bride price (centered on cattle) remains quite the same. Even if a couple meets and marries elsewhere (e.g., while in school in Ethiopia, Uganda, etc.), the man's father must still pay the traditional cows to her father.

A second important change is in the number of men who said they would consult with health care providers when they are unable to have a child.

Another shift appears to be a trend to fewer wives, especially in urban areas, although polygamy remains common.

In WBEG, traditions appear to be changing for some but not others. As might be expected, the more rural areas are holding more strongly to tradition (although some in urban areas also expressed very traditional views on marriage and childbirth). For example, a 33-year-old Dinka soldier—Christian with three wives—said "The father should decide when and whom to marry. Young men should marry at age 20–25. They should start having children right away because that is the purpose of getting married. If not pregnant in six months, the woman should be sent back to her parents…a man can have as many wives as he can maintain."

[14] Likewise in the GOSS-UNICEF study, "Maternal and Newborn Health Formative Care in Southern Sudan," FGD participants in Western Equatoria said that FP is not culturally acceptable and people are supposed to have as many children as God can give them (2010, p. 71).

PREVENTION OF PREGNANCY AND UNWANTED BIRTHS: TRADITIONAL NORMS

The norms described here are generally followed by persons who are now middle age (about 35) and over. These norms are also present in varying degrees among the younger generation depending on geography—those living in a city or town vs. those in remote villages.

Traditional Attitudes about Preventing Pregnancy

Many interviewees and focus group participants seemed puzzled by the study questions on traditional ways to prevent pregnancy. In their minds, pregnancy was never considered something to be prevented. On the contrary, the purpose of marriage was to produce children for the husband, which is why his father paid the bride price, often sizeable (many cattle), to the bride's family. "*If she does not produce children, why were the cows paid to her father?*" is the common thinking. Others said: "*Children are from God, so they should not be prevented*" and "*Preventing pregnancy in our community is bad, because it is God who provides, but not human beings*."[15]

The postpartum sexual taboo

While pregnancy was not considered something to be prevented, a very strong postpartum sexual taboo did prevent children from being born close together. In all three states, and Juba, child spacing is a deeply-rooted and valued cultural norm. Traditionally this is achieved by two-to-three years' postpartum sexual abstention while the mother breastfeeds her child.

In Upper Nile, all interviewees—Nuer, Dinka, and Shilluk alike—said that their culture has a three-year period of postpartum sexual abstinence, during which the mother breastfeeds her baby and sex is forbidden. This is based on the cultural belief that if the couple has sex while the mother is still breastfeeding, a curse will befall the child and family—making the child sick (diarrhea, vomiting, emaciation). It is believed that the curse might not only kill the child, but all of the children in the family or cause disease outbreak in the family.[16] (Among the Bor Dinka this is called *meth-e-thiong,* literally, "the child is filled up." Among the Nuer it is *thiam.)*[17]

With such dire consequences believed to result from sex while breastfeeding, the husband does not pursue sex with his wife. This is enforced by the watchfulness of the couple's parents, especially the mother's parents. "*If a woman became pregnant before the three years was over, the community criticized and mocked the man and his family,*" said many interviewees.

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[15] Much was said (and is stated below in this report) about the definite relationship of child spacing to women's *health*. But respondents said little or nothing about the relationship of child spacing, or fewer children, and a woman's ability to be "socially and economically productive." This latter is a more "modern" concept that does not figure in the daily realities of women's poverty and subsistence.

[16] Child spacing has long been embedded in African tradition. An analysis of "Postpartum Sexual Abstinence in Tropical Africa" begins: "The first fact about Africa, south of the Sahara, is that there are usually strong public and private norms about birth spacing as a behavior necessary for the health of the mother and the child…Maybe more than anywhere else, individual women have a clear notion of an ideal spacing between births. Survey questions on family size often leave African respondents puzzled and many will answer that the number of children is 'up to God.' In contrast, a question on the optimum interval between births usually elicits a precise answer. Length of ideal spacing may be stated to be between two and five years depending on age, parity, local customs, and sometimes personal preferences. At any rate, public opinion universally approves of a reasonable interval between births" (van de Walle & van de Walle 1989).

[17] "Spacing births is so inherent in African culture that there exists a name in most languages for the woman who becomes pregnant while still nursing. These names imply disapproval, mockery and other negative connotations" (van de Walle & van de Walle 1989).

Informants said that it is not necessary for a husband to have multiple wives in order to abstain. Rather, the husband and wife traditionally live far apart during the three postpartum years. Following the birth of her first child, a mother may stay with her own mother—who assists with the delivery and teaches her daughter how care for the baby. This arrangement in particular keeps the husband away from his wife and promotes abstinence. It is considered shameful for the husband to sneakily try to see his wife at her mother's home.

Some informants expressed this as "*The mother would breastfeed until the child could come running to her and speak to her.*" At that time, which occurred at three years, the husband could again have sex with his wife.

It is less common for the wife to return to her mother's home for subsequent births after the first. Then, the husband and wife live in different huts and their parents monitor the separation of the couple.

Significantly, it appears that this long-standing tradition of child spacing is not seen as "preventing pregnancy."

Most women interviewees do not believe that breastfeeding itself prevents pregnancy. Rather it is sexual abstinence during the extended breastfeeding period that prevents pregnancy.

From the Western Equatoria report:

> "Child spacing is practiced in Western Equatoria for a minimum of 1.5 to 2.5 years. This is often achieved through postpartum sexual abstention, or couples sleeping in different places, while the woman breast-feeds her baby for a period of 1.5 to 2.5 years. A few men take a second wife while the first wife breastfeeds her child. These natural methods are used by almost all couples, regardless of their educational background or where they reside. According to many of the informants, the process of breastfeeding usually lasts up to 2 years, unless there is a sudden pregnancy that causes the woman to stop breastfeeding her baby."

Other "folk" methods

Withdrawal is not a traditional method. When the Upper Nile team asked about withdrawal, informants laughed loudly at the question. "*That would never happen here!*" In WBEG, however, some men said they do use withdrawal if their wives are still breastfeeding.

In WBEG, a handful of women respondents mentioned a few traditional methods to stop childbearing completely (other than abstinence for the rest of their lives, which was mentioned or implied by several). These included:

- Get a small round stone, spit on it, take it to any junction, and bury it in a hole there.
- Lock yourself into a room, have your elder son come and knock on your door three times. He knocks and calls you, and you insult him three times.
- Ganduru method: mix menstrual blood with dirt, put it in an anthill, and cover.

Women in a FGD in Kediba, East Mundri, said they would take quinine drugs to prevent pregnancy. Several respondents mentioned that both men and women use paracetamol to prevent pregnancies.[18]

[18] Paracetamol, known as acetaminophen in the United States, is a pain reliever and fever reducer that is popular throughout the world—and a standard drug in South Sudan, especially for treating fever.

Extramarital Pregnancy

Most people have negative attitudes toward extramarital pregnancies.

Unmarried girls

Traditionally, and generally still today, if an *unmarried* girl gets pregnant, she is sent to the home of the man who impregnated her and he must marry her and pay a bride price. However, some men deny that they are the cause of the pregnancy and therefore do not pay any bride price. If a girl refuses to reveal the name of the man, she may be allowed to stay in her parents' home. There are also cases in which the pregnant woman is sent away from home and resorts to an induced abortion. The final decision about abortion depends on the woman and her family, with some opting for abortion while others choose to remain pregnant.

In recent years, Western Equatoria has seen an increase in the number of unmarried, underage girls who become pregnant and then drop out of school. Often the men don't take full responsibility for the pregnancy and the girl's family must continue to provide for her and her baby.[19]

In WBEG, participants frequently identified out-of-wedlock pregnancy as a major problem. Women in Wau complained that young girls miss classes to be with men, and thus become pregnant and drop out of school.[20]

Married women

If a woman is *married* when she becomes pregnant by another man, respondents said that the case is often taken to court. In such cases, the offending man usually pays some cows to her husband and she returns to her husband.

Abortion

Respondents in all three states have very negative views of induced abortion. In discussing abortion, many respondents assumed the question concerned spontaneous abortion, with which many are familiar. When it was clarified that the question was about induced abortion, participants in Upper Nile were taken aback, shaking their heads to reject the idea. Many said that to abort a child is considered a sin and "not possible," and that a woman who becomes pregnant outside of marriage would never abort the fetus. It is believed that children are the creations of God. A common response was: "*Abortion is bad because it is God who provides and God who takes—but not human beings*."

However, according to many respondents in Mundri, Western Equatoria, there are cases in which a pregnant woman is rejected by the man who impregnated her and she is sent away from home. In this case, she may resort to an induced abortion. The final decision about abortion depends on the woman and her family, with some opting for abortion while others choose to remain pregnant.

> "It [abortion] is bad, very bad, in our tribe as Balanda people. And if we learn that you have done so, you will be excommunicated from the village."

However, there is a great social stigma associated with abortion and many consider it to be a crime. If a woman dies as a result of an abortion, people don't mourn her death.

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[19] Extramarital pregnancy also affects young men's life chances. A key reason boys drop out of secondary school is having impregnated a young woman and then being obliged to marry her or otherwise support her and the baby. (Reported by the USAID/South Sudan Education team.)

[20] Below, we will see that many such young women are interested in using contraception in order to prevent pregnancy and remain in school.

It is said that, in most situations, Mundri women perform the abortion themselves. They said, "*We use the seeds of okra."* Dried okra seeds are pounded into a powder, which is then mixed with water and consumed. Within a short time, the fetus is expected to abort. Other respondents, in an FGD of young women, said that some women use the roots and leaves of a certain *gita nyuaa* tree, which are ground into powder and then mixed with water to drink. Some women take a heavy dose of quinine drugs to cause an abortion. In case of complications, the woman is taken to a health facility. Some respondents in WBEG said that midwives or traditional birth attendants (TBA) perform abortion, while most, especially service providers, said the pregnant woman performs her own. One person said that the mother of an unwed pregnant girl performed the girl's abortion.

Postpartum Sexual Abstinence: A Continued but Shifting Norm

In Upper Nile, older persons believe that the three-year abstinence period is an excellent system. They lament that this norm is eroding with "civilization" and people being "mixed up" in city and towns, noting that not all young people observe the tradition. The disruption of family life and movement of persons during the 50 years of civil war are major contributing factors to the changing of this tradition.

Today, the period of expected abstinence has shortened to about two years. "*Now spacing is about 2 to 2-1/2 years, but it is important to space children 3 years"* was the consensus of one focus group with men. Even this two-year spacing is not rigidly adhered to in more urban settings, with "*many children coming every 1-1/2 years*." Couples living in town no longer have the parental intensive governing of their comings and goings. Further, the husband and wife no longer live apart, which makes abstinence much more difficult. The couple may live in separate huts in the same compound. Or they might sleep in the same hut, but one that is large enough that the wife sleeps on one side and the husband on the other with children in between. Whichever, the couple is physically much closer and thus the temptation is greater than in traditional communities. Men in one FGD agreed: *"Husband and wife are sharing one room, not like in the old days when the couple is separated when a woman has a small baby."*

Still, elements of the tradition persist. This study asked women: "What do you do if you don't want to get pregnant?"

- A Nuer village woman, age 28: "Be away from my husband. I will go to my mother's house and he will not go to me there."
- A Dinka woman: "I stay away from my husband. I and the children sleep in one bed and my husband sleeps in his bed. We don't meet."
- A Nuer woman, age 26: "If my child is not 2 years old, then I cannot accept to sleep with him and we can fight if he doesn't understand me. Then I will go to my mother's house." [Whether in the same village or far away, such as in Juba.]
- Woman in peri-urban focus group: "If I'm breastfeeding and he beats me [because I will not have sex with him], then I will go to my parents' home and wait until the child space of three years is reached."

In Mundri, it is believed that the natural methods of postpartum abstinence and breastfeeding are good for the health of the mother and baby. If the mother doesn't get pregnant immediately after giving birth, the baby has the chance to be breast-fed for about two years while the mother rests and recovers from the pregnancy. This pattern has not changed throughout the years and continues to dominate until now.

However, a female FGD (in Hai Telmia, UNS) expressed consensus that it is impossible for a wife to repeatedly reject her husband. Some younger urban women see the advantage of using contraception—especially pills—in this situation. Most do it secretly.

In WBEG, one interviewer observed that abstinence no longer seems to be working in Angisa because "men can beat their wives up if they deny them sex."

Breastfeeding and Pregnancy: Traditional and Today

Do People Believe that Breastfeeding Prevents Pregnancy?

Breastfeeding is closely linked to child spacing and prevention of pregnancy. A few respondents believe breastfeeding prevents pregnancy, but the majority said that *breastfeeding itself does not prevent pregnancy.* Rather it is sexual abstinence while breastfeeding that prevents pregnancy.

What Happens if a Woman Becomes Pregnant While Breastfeeding?

As explained above, if a woman gets pregnant while breastfeeding, she must stop breastfeeding immediately and continue with the pregnancy. This belief, still firmly embedded in the local cultures, dictates that a new pregnancy will cause a serious condition with deleterious effects on the health of the nursing child, including diarrhea and even death. Many believe further that it can cause death to other children in the family as well, or even bring disease to the whole family.[21]

Duration of Breastfeeding

In all three states, and Juba, interviewees said it is the norm to breastfeed for two years, or three years if possible. Today, the norm and desired duration has generally shortened, especially in the urban setting, from three to two years.

Dinka and Nuer interviewees said that it was standard for mothers to breastfeed their child until the age of 3, at which point the child should be able to run to her and speak to her. That is the time for weaning. Weaning, they said, was traditionally accompanied by provision of a cow for the child, replacing mother's milk with cow's milk. All informants said this extended breastfeeding is good and important for the health of the child as well as the woman.

When is Other Food Introduced?

The majority of women, both in interviews and in FGDs, state that they begin to give their babies additional foods at 6 months of age. It is not clear if this is truly the case. The alternative may be that so many women have heard and remember the message about exclusive breastfeeding to six months that they feel this is the "correct answer" to give.

One man, however, stated that his wife breastfed their children for two years "*because we can't afford food."*

In WBEG, respondents said that every (urban) woman breastfeeds at least 1 1/2 years. In rural areas they do so up to three years. Mothers typically offer complementary foods at 3 to 9 months of age.

LIVING CONDITIONS AND HEALTH CARE SEEKING

Daily Life is Difficult and Becoming Harder

Many people are struggling with poverty. Most respondents said life is difficult with the most common reasons being financial—with high prices in general, and food, education, and health care for children being expensive.

[21] There is no evidence of any knowledge or introduction of the lactational amenorrhea method (LAM) in Upper Nile State, but it appears possibly known by a small minority in other states. Contemporary medical evidence validates South Sudanese folk wisdom concerning health benefits of extended breastfeeding and delay of subsequent pregnancy.

In both rural and urban areas, the majority of women in the sample are housewives. They typically spend their days cleaning the home or compound, retrieving water, cooking and caring for young children, and seeking ways to get cash for food. To raise money, some women make charcoal or local beer, gather and sell grass, or garden and raise chickens and goats. Very few women have jobs that bring cash income. In the Western Equatoria sample, a few women are working in professional careers such as teaching, nursing, or midwifery.

Urban men work outside the home in many types of jobs, typically ones that do not require much education; in rural areas their work also includes farming. Mundri men in West Equatoria said that their main problems revolve around unemployment and inadequate sources of income. Most of the respondents said that they depend on the sale of their agricultural produce for any cash income. Jobs are hard to find and capital to invest in businesses is scarce. The educational level of men is generally low.

Many men in all three states migrate to distant places for work, often leaving their families for three to six months or even one year. When their husbands are away, women in Upper Nile and WBEG said they make most household decisions; while Mundri men said decision-making is relegated to other men in the husband's family. Several female respondents in Wau County said that their husbands work in cities, and return home on weekends, once in a while or never. One mother of five said her husband went to Juba for job, but has never returned or communicated with her.

Women's Perspectives

Nearly all women, in both interviews and FGDs, immediately emphasized the difficulty of life, which for most is at the subsistence level. Among the states investigated, difficulties are similar but also vary in detail because of South Sudan's varied ecology. In the Mundri sample, women's fears included endemic diseases, river blindness (mainly in Amadi Payam), nodding disease,[22] diarrhea, syphilis, and malaria; both rural and urban women complained about painful menses/lower abdominal pains, spontaneous abortion, urinary tract infections, and respiratory tract infections. In Upper Nile, daily difficulties most often cited are:

- Poverty.
- Lack of, and expense of, food.
- Not enough variety in the diet; rarely have fruits or vegetables.
- War left a burden on women to pay school fees and take care of the orphans.
- Daily tasks such as retrieving water from the Nile and cleaning the compound.
- Cutting grass for sale in order to secure food (among rural women).
- Most women are not employed, thus depend on men for cash. Only a few urban women have paid employment.
- Giving birth every 1-1/2 years, and this leading to death of women.
- Some women die giving birth because of lack of food, lack of medicine, lack of awareness in terms of antenatal care (ANC).
- Disease: malaria rate is so high.
- Don't have proper medicines.
- Focus group in Hai Telmia: We don't have water, roads are terrible, we can't move. No electricity.

[22] See Nyungura, et al. "Investigation into the Nodding Syndrome in Witto Payam, Western Equatoria State in 2010." *Southern Sudan Medical Journal*. Vol. 4. No. 1. February 2011.

- Focus group in Thoura Jalaba: We don't have clean water; have to go far to the Nile to bring water. It is not clean; sometimes it may be contaminated; and because of our new nation, this will be addressed or solved by our Government of South Sudan.

Men's Added Perspectives:

- The market is getting much more expensive.
- Cutting trees to sell; making charcoal.
- The situation is very bad. No clean drinking water. Bad roads. Bad health facilities; not enough beds in the hospital. This differs one season to another. In the rainy season the environment is not good—drainage system is poor, with lots of mosquitoes bringing malaria.
- Transport is always a problem and costly. Bad roads are worse in the rain.
- Sickness is very high. No means to transport a person to the hospital in case of emergency.
- Child death rates are very high.
- Schools: There is high dropout rate among students. The education standard is dropping; teachers are not qualified/professional. Many school children leave school early on many days because of hunger.
- Insecurity due to rebel attacks in the area (UNS).
- Insecurity due to cattle raiding.

Irresponsible Husbands and Violence Against Women

Women in all three states, and Juba, report being beaten by their husbands. Many female respondents reported that their husbands beat them if they refused sex ("to open for the man" was one common phrase). Women in Mundri said that many men drink alcohol excessively; several women mentioned that drinking alcohol is a problem that causes husbands to be irresponsible, leading to family violence and often divorce. (Divorce was often mentioned in all three states.)

A few women respondents referred to and criticized their husbands as "irresponsible." In the Mundri West and East sample, women married to men whom they referred to as "irresponsible" have to independently cultivate land, cook, clean, carry firewood and water, and care for children—some do so in addition to running small businesses. Some women also raise goats and chickens to sell for cash.

A very small number of men and women in urban and rural areas said either that life is good or that they have no problems.

What Makes a "Good Man"?

Men were asked this question (which was aimed at illuminating responsibility for children). Most common answers included responsibility to the family and helping others in the community. Respondents specified:

About family:

- Provide food for the family; make sure that the family and children get food to eat.
- One who does any work to bring food for the family.
- Know how to live well with your family: not being a drunkard, do all things according to the standard (e.g., school, health of the children, not fighting with your wife).
- Take care of the health of his children and wife.
- Asking about the family from time to time.

- A man who marries only one wife.

About community:

- To be honest, respect people, help the community, assist people in need.
- Someone who doesn't create conflict in the community.
- If possible, he gives food or cattle to someone who has none.
- A man who usually reconciles people.
- Who participates in other people's occasions (sorrow or happiness).
- Don't wish bad to other people.
- Have more friends.
- People like him.

Health Care Seeking: What Do People Do When They Are Sick?

Sickness and affordable treatment are major worries of the population. Sickness is common; and while curative services are available, they are often far from people's homes and unaffordable.

Men, women, and providers lamented the cost of treatment; the distance to health facilities; the lack of transportation for rural people; inadequate infrastructure (from age and size of buildings to lack of water, sanitation, and electricity); lack of drugs; and inadequate numbers of trained staff.

The teaching hospitals—despite their costs—are clearly the preferred source of care in the city (Juba, Wau and Malakal) and nearby areas. In Malakal, respondents praised the GOAL "hospital," but lamented that it now charges fees since the government took it over from the founding NGO.[23]

Some interviewees said they go to the PHCCs and the PHCUs. "*But these places lack medicines and qualified personnel,*" many complained. Others said: "*But these PHCCs are not working during night time*." Some respondents mentioned availability of private clinics, "*but only if you have money."* In Malakal, the Anglican Bishop stated: "*Medical facilities are not enough. There are many returnees who don't get served."*

Cost

Cost and distance were the two primary impediments to seeking health care. Nearly every single respondent said cost is a major barrier. For many, this cost barrier results in death (for those who don't have money to get to a health facility or to get there soon enough). All health centers request at least some payment. At government facilities, while care is allegedly free (the RSS Constitution calls for free health services for all at the primary health care level [PHCU and PHCC]), there are many additional costs associated with health care. In Wau, costs are said to range from 2 SSP to 30 SSP or more (30 SSP is cited as the cost of a malaria injection). At Malakal Teaching Hospital (MTH), for example, checkups (e.g., drawing blood, testing for malaria) and getting drugs is considered expensive, at up to roughly 200 SSP.[24] Respondents report:

- *"If you don't have money, you can't go; must stay at home."*
- *"Availability of cash is the most important factor. If there is no money, the child cannot be taken to the hospital."*

[23] According to USAID, however, GOAL runs PHCCs in two counties and hopes, in the long run, to upgrade the PHCCs to county hospitals.
[24] One SSP is equal to about one-third of a U.S. dollar. Thus, 200 SSP equals about $60 USD.

- *"It is not free, although they say it is free."*
- *"Malakal Teaching Hospital seems like it's doing a business, because they charge for so many things."*
- *"The hospital doesn't have enough drugs. It prescribes so many medications you have to buy in the pharmacy that cost a lot of money."*

Insufficient drugs are likewise a major problem in Raja County, WBEG. There, respondents said that it takes too long to deliver drugs from Juba to Wau to Raja—or that drugs never arrive. They believe that government and donor-funded drugs are diverted to private clinics. This was a common belief in Malakal as well—that the government provides the hospital with needed drugs, but that doctors sell those drugs in a private practice or pharmacy outside of the hospital.

In Western Equatoria, the cost of transportation also determines where people seek medical care. Some people go to Lui Hospital, if they can find reasonable transportation. Patients who are admitted to Lui Hospital have to pay a bed fee each day that they are in the hospital. Health care facilities are not easily accessible, especially in the rainy season. Some respondents mentioned that they have to pay for expensive transportation to go to a hospital that is located more than 30 miles from their homes. There are no emergency medical services such as ambulances. A small number of men, mostly in urban areas, said they visit private clinics to buy drugs they can't get from the PHCC/U.

Also, the PHCCs/Us open late and close early, and some people are not satisfied with the irregularity of service hours. According to respondents, this is due to a lack of supervision of the staff or an irregular payment of the staff's incentive pay.

Health Care Decision-making

The study asked "Who decides if the wife or her child goes to get care?" Answers varied. Many women in both rural and urban areas said they decide on their own. *"The wife usually decides, but she must get money from her husband."* Some men, however, said that they make the decision: *"The head of the family is a man; therefore the husband is the one to decide if the children or his wife go to the hospital."*

Are People Happy or Unhappy with the Services They Get?

While some respondents said the doctors at the hospital are okay or good, generally, people are dissatisfied with the services they get. Their reasons include everything from the cost of service, to the insufficient supply of drugs, to the lack of sufficient personnel and space, to the congestion in the health facilities, to how some health personnel are not kind or honest with patients. Transport to the hospital is also expensive. A minority, who have jobs that provide cash income, said they are satisfied with the hospital because they can buy the extra needed medicines from a pharmacy.

In Wau County, FGDs and interviews were held at two JSI-supported clinics. Satisfaction with these clinics was generally high. Respondents in those communities said that medicines were typically provided at the clinic.

The Village Perspective

Wau Shilluk, a Shilluk village on the Nile. Wau Shilluk has a PHCU (established previously by OXFAM, now under the government with support from IMC). Interviews and focus groups emphasized the inadequacy of the PHCU:

- *"Some people go to the PHCU; this is walkable. It does dressing of wounds, immunization and consultancy, but it lacks medicines, equipment, and qualified personnel."*

- *"The village PHCU has no lab, so people can't get tested to determine if the sickness is malaria or some other. Must go to the hospital for this—if a person has cash."*
- *"It [PHCU] has no maternity ward or bed, so it cannot assist women in childbirth. So most women deliver at home."*
- *"If the condition is serious, some go to Malakal Teaching Hospital, but often they arrive too late…Malakal Hospital is very far—30 minutes with speedboat and three or four hours walking."*

Obel, a Nuer village on the Nile. Obel has a large hospital building, built about 2004 and supported earlier by World Vision, which is the site of a PHCU. However, it lacks even the most basic equipment. The medical assistant has only a stethoscope—no thermometer or blood pressure cuff. It lacks needed medicines (it has some antibiotics and a lot of paracetamol). It has no lab. It has no beds for in-patient care or for women to give birth. While it has one midwife, a former TBA who was trained by World Vision and helps women during pregnancy,[25] it lacks a trained, qualified midwife who can provide assistance for more difficult births.

Traditional Medicine, Midwives, and Healers

Use of Traditional Midwives

Most women—urban as well as rural—give birth at home, often assisted by a *daya* (traditional midwife). Other women may be assisted by an older woman who is not necessarily a *daya*. Most *dayas* help only during delivery, although some provide other help or advice for the mother or child (e.g., on sickness or nutrition).

- One Mundri women said: "Every time a woman is in labor we send for the daya. We like them because we pay them only small amounts and a bar of soap in appreciation, yet they do a good job."
- An Upper Nile woman said: "Local dayas assist with the delivery, because any health facility is far away. Now that we have a new nation, maybe our government will provide good services."

At MTH, about 25 *dayas* work in the maternity ward, which is an attempt to compensate for the shortage of trained midwives and nurses. Two UNFPA contract midwives (international UN Volunteers, one Kenyan, one Swedish) are striving to build capacity of the *dayas*.

Traditional Healers

Traditional healers no longer provide the majority of care as in previous decades. Local people appear to associate traditional healers with abandoned native religions. Many respondents answered that they do not or would not go to a traditional healer "*because I am Christian*." A few respondents said they go to traditional healers, citing financial reasons. "*If I don't have money for the hospital, I go to a traditional healer, which is cheaper."* Other respondents said they use or would use traditional healers, especially if modern treatment did not work, for cases of severe and recurrent headaches and convulsions or if the problem was due to witchcraft.

Traditional Medicine

A few respondents mentioned using an herbal remedy. Said one woman: "If you don't have money to take yourself or your child to a health center, you will be forced to take the bark of a nime tree, boil it, and drink it as medicine."

[25] This is typical of many areas where the terminology "midwife" is used for village midwives or traditional birth attendants (TBA) who are usually illiterate and have only minimal training, if any, by the medical system.

MATERNAL MORTALITY AND FAMILY PLANNING

Dying in childbirth is familiar to all. Nearly all persons interviewed personally know at least one woman who died in childbirth and can usually describe the cause of her death.

Perceptions of Cause

Service providers recognize the likely role of too early and too closely-spaced pregnancies in many of those deaths. But most community people do not directly associate maternal death with birthing too many children or having them too close together. Some respondents, however, said that frequent deliveries cause the uterus to become weak or "light," which can cause the mother to die when trying to give birth.

Most commonly cited reasons for maternal death were:

- Lack of health facilities in rural and some urban areas.
- The hospital/facility is distant; cost to get there is expensive. Women usually have to walk long distances.
- Poor quality of facilities and services; lack of trained midwives.
- Some women are anemic ("lack blood"), thus are disposed to heavy bleeding after delivery.
- Some women have malaria.
- Women lack enough food.
- Long distances to health facilities, hence most women don't go for ANC. [26]
- Men need to follow their wives during the pregnancy. Encourage her to eat good food, seek ANC, etc.[27]

In rural WBEG, malaria, poor feeding, hard work, worms, untrained midwives, lack of transport to hospital, and bewitchment were mentioned as causes of maternal deaths.

When asked how to prevent or reduce maternal deaths, most respondents said more midwives should be trained and available; women delivering for the first time should do so at a qualified facility; each village should have an ambulance for emergency cases; and maternity homes should be made available near the hospital for women to stay in before going into labor. The WBEG study team encountered a woman in Angisa who had been in labor for 16 hours. It was the woman's first pregnancy and she had been counseled earlier to go Wau Teaching Hospital (WTH) to deliver, but the family did not have transportation for her. Luckily the study team was able to transport her to WTH where she delivered safely.

One woman in an FGD arrived at the following synthesis:

> *"Some women die when they give birth because of lack of food, lack of medicines, lack of awareness in terms of antenatal care, and diseases that cause miscarriage. Because of our new nation, all these issues will be addressed or solved by our Government of South Sudan."*

[26] The few clinic records during the study examined showed several women having one prenatal visit, but very few having the recommended four visits. The term "ANC" or "antenatal care" is not widely known, but was recorded by this study's data collectors whenever a respondent referred to women getting a checkup during pregnancy.

[27] No respondents mentioned female genital cutting. In another report, (Government of Southern Sudan, Ministry of Health, in Collaboration with UNICEF, 2010, p. 80) female genital cutting is identified as a major impediment to safe motherhood in Upper Nile State.

BIRTH SPACING, FAMILY PLANNING AND CONTRACEPTION: KNOWLEDGE, ATTITUDES AND PRACTICES

There is a great difference between urban and rural populations in many ways—knowledge, attitude and practice—with regard to FP and contraception.

How Widespread Is *Knowledge* of Family Planning and Contraception?

In rural villages, many have not heard of the term FP. In urban centers, many have heard of FP and contraceptive methods, but their knowledge is generally more awareness than accurate knowledge.

In Mundri, most of the male respondents understand FP as the way they plan to meet the needs of their families, in terms of providing food, shelter, healthcare, education, and so on. Likewise in WBEG, at least one person defined FP as bringing family members together to plan for the family.

Question: What is "family planning"?

Common urban responses in Malakal:

- *"It's a drug for preventing pregnancy."*
- Something such as*: "It's limiting the number of children. The couple must have only 4–5 children."*
- Common village responses:
  - Nuer village woman, age 28, who had not heard the term: *"The family must organize themselves to be respectful."*
  - A man in Wau Shilluk village: *"It's organizing the family and children, providing housing, food and clothes."*
  - Nuer village chief: *"It's medicine to organize the family."*

In WBEG, many respondents in rural areas had not heard of FP or modern contraception. In Jur River County almost no one had heard of it and most did not want to learn about it.

Family planning is usually translated, in local Arabic, as *tanzim al usura*. However, one service provider said there is no word for FP in the languages used in Jur River villages.

What Methods of Contraception Are Known?

There is some variation among the states when it comes to knowledge of contraceptive methods. In Upper Nile, most commonly cited are pills, followed by injection and "Jadelle" (Norplant II). The medical assistant at the "family spacing clinic" at MTH, operated by American Refugee Committee (ARC) with UNFPA support, said many women are now choosing an implant. According to the UNFPA contract midwives at MTH, "Women love Jadelle—more than pill, coil [IUD] or injection."

Condoms are generally *not* considered as a contraceptive method. Many respondents—men and women, pharmacists also—have heard of condoms, but do not identify them as a contraceptive method. When the study team went to pharmacies and asked what contraceptives they had, pharmacists mentioned pills and sometimes injection, but not condoms. However, when directly asked about condoms, the pharmacists said yes and presented silver strips of three condoms each from Korea.

In Mundri, Western Equatoria, the most commonly known methods are the pill, injection, and condoms. The majority of the rural population is not familiar with these modern methods, but they have heard of them and can name a few. Those who mentioned these methods said they heard them from their friends who had tried them, but did not know how they worked. Condoms are commonly used by urban men, but most of them said they did not use condoms to prevent pregnancies. Rather, these respondents said they often used condoms for the prevention of HIV and other STDs.

In WBEG, the most known methods are the pill and injection. A few respondents had heard of the IUD. Condoms, for the most part, are considered a method of disease prevention—not pregnancy prevention (even in urban areas). Many respondents knew that pills should be taken daily; that injections are given every two or three months; and that condoms prevent STDs as well as pregnancy (with pregnancy prevention being incidental).

"Counting the Days"

A small number of male respondents refer to "counting the days" or having sex only during "safe days." They do not seem sure, however, of how the "safe days" are determined. Some said this may be just two days before or four days after menstruation. Others said it involves counting 15 days from menstruation. Some seemed to think the unsafe period was while the woman menstruated. Some men who have more than one wife will only have sex with the wife who is perceived to be on her safe days. "*But counting days cannot be taken for granted*" was the consensus of one male focus group.

Awareness of Contraceptive Methods—but Not "Family Planning"

While some respondents said they have not heard of FP, they name at least the pill when asked: "What modern methods to prevent pregnancy have you heard of?"

How Accurate Is Knowledge of Family Planning and Contraception?

Even among those people who have heard of pills, injection, or other modern contraceptive methods, most lack *accurate* knowledge. Family planning is not an easily understood concept. Given that many men especially want "as many children as possible," the idea of planning a family does not fit with any worldview or concepts of life for the majority of people. In general, rural women and men who have heard of family planning think that family planning is for limiting births, which is anathema to most.

Lack of *accurate* knowledge is both a barrier to starting a method and to abandoning a method. (See the profile of Rebecca below.) The comment of one 29-year-old woman in Malakal is typical:

> *"One of my friends from Ethiopia was telling about the condom and pill when she visited my house. I know some women get the 'pill for preventing pregnancy' from the pharmacy, but I don't know if it works or not."*

Respondents in all categories (even service providers and pharmacists) have misconceptions and negative views about FP and contraception based on incorrect understanding of contraceptive methods. In all three states, numerous respondents stated that pills are bad because they can permanently prevent pregnancy. The same was said about injection.

- *"If a woman takes the pills, she may never be able to have children again." or "Pills prevent pregnancy permanently."*
- *"Pills cause the uterus to close up." or "Pills block off the uterus permanently."*
- *"Contraceptives can cause cancer and infertility."*

Even some health care providers believe and advise incorrectly. A medical assistant at one PHCU said the injection is bad for women because it can cause permanent infertility. An Anglican church leader (who now actively supports use of contraception) had been told the same thing—and consequently had more children than wanted. In Jur River County one pharmacist recommends that his customers alternate injections with a month-long course of pills.

Attitudes and "False Knowledge" about Family Planning and Contraception

Among those who have heard of FP or contraception, attitudes are mixed and reflect lack of accurate knowledge.

"Family Planning Is Bad"

Among those who have heard of FP or contraception, the majority of respondents in all three states believe it is bad. Most common reasons cited include the following morality-based judgments:

- *"Family planning is bad because children are from God."*
- *"Family planning means you have to limit the number of children."*
- *"Family planning encourages immorality."*
- *"Some people think that family planning is a crime."*
- *"It's a bad thing because it will create a problem in the community. People will start playing sex in an abnormal way. Women will play sex out of marriage. The girls will not be controlled as they will play sex and nobody will know."*
- *"Taking pills to delay pregnancy is a bad omen."*
- *"Women who use pills can easily have sex with other men—and will."*
- *"Pills are used by prostitutes. If a woman uses the pills, she may become a prostitute."*
- *"Condoms encourage men to have sex with women other than their wives."*
- *"Condoms are used by bad men and prostitutes."*
- *"We marry to get children. It is God who prevents pregnancy, not man. Let them not bring this idea to this payam."*

Many men and women have strong biases against contraception:

- *"We don't want these things. Even if they are brought here, I don't want them. If I hear that my wife is using it—that is the time I will divorce her" A rural man with little primary education in Mundri West.*
- *"If I hear that my son or daughter is using any of these methods, I will jail him/her." A male respondent, with had no formal education, in an FGD in rural Amadi, WBEG.*
- *"No woman should use these things and even the people of the PHCC should not risk bringing them in the center." A woman in Mariel Ajit, WBEG, who called herself the leader of the women.*
- *"A wife who uses contraceptives behind her husband's back is often divorced immediately." CHW in Western Equatoria.*

"Contraception/Family Planning Is Good"

A minority of respondents believes that contraception is good and this correlates with education. (Even those with some primary school education are more likely than those with no schooling to view contraception or FP as good.) Proponents generally cite the following reasons.

1. With the difficult economic situation, it is hard to provide for a large number of children. *"It is a good thing for married people, because people's income is less with more children. This can be addressed through family planning."*
2. Contraception enables the couple to have sex while also spacing their children. *"Pills make it possible to 'open' to my husband and still continue breastfeeding, because I will not become pregnant."* and *"With injection, I avoid my husband beating me and avoid becoming pregnant while still breastfeeding."*
3. Contraception is good for a woman's health. A focus group with men concluded: *"It's good to keep the women's health good."* From a woman's perspective, contraception allows her to *"take a rest from pregnancy."*
4. Contraception also allows women to continue schooling. *"With contraception, a woman can continue her education."*

Family Planning vs. Child Spacing

While a majority of respondents view family planning (*tanzim al usura* in local Arabic) negatively, everyone believes that child spacing is good.[28] Child spacing (*feriku welada ta iyal*, in local Arabic) is a longstanding tradition seen as very positive—to the point that some communities shame men and women who have closely spaced children. Child spacing is considered good because it allows both the child and the mother to become strong before the mother becomes pregnant and gives birth again. It is universally believed that the old system of abstinence was good and that, nowadays, there should still be at least two years' spacing between pregnancies and children.

Participants were asked "Is there a difference between birth spacing and family planning?" While some respondents stated that they are the same, many understand them to be different. The following response, from a women's focus group, is representative:

> *"The difference is that family planning is prevention of pregnancy, whereas birth spacing is maintaining the interval between children."*

One woman from Bussere (WBEG) said there is a difference because a doctor gave her pills and said, "These are for spacing, and if you want to stop producing you can come back and I will give you family planning."

Practice: Current Contraceptive Use

There are no cumulative data on contraceptive use in the three states. Individual providers (see section 6 below) keep some data on users, but these data are not systematically reported to any central state office.

Relatively few respondents said they used or had ever used modern contraceptives at the time of the study. Our research found just several young women and couples who said they are using, or have tried, a contraceptive method. Regarding current contraceptive use, the major conclusions emerging from this study are the following:

- The use of contraception is by women for the purpose of child spacing.
- The main method is the pill, followed by injection.
- Women tend to use contraception secretly from their husbands, fearing problems, including physical abuse, and even divorce, if use was known.
- Many women who try contraception do not use it correctly. For example, according to the pharmacist at ARC's "family spacing" center at MTH: *"People are not using it in the right way.*

[28] "Child spacing" is more commonly said in local languages than "birth spacing."

They misuse it. Like they take the pill one day, but if they are not meeting with the man they will not take it."

- *The health providers in various health facilities do not have accurate information on FP principles, practices, benefits and correct use.*
- Some health providers have a negative attitude about FP.

Contraceptive Decision-making

Interviewees who have used contraception answered the following questions:

- "Why did you decide to use contraception?" The most common responses were the following:
  - *"To allow space between children."*
  - *"I am breastfeeding and am physically close to my husband."*
  - *"I decided to use contraception because I want to continue with education."*
  - *"To take a rest between children."*
  - The husband does not take adequate responsibility for wife and children. For example: *"My husband has four other wives and I have four children, but my husband is not helping me. I am taking all the responsibility."*
- A few women said they would like to use contraception because they do not want to have any more children:
  - *"I don't want to have any other children; these eight children are enough for me,"* offered one woman in WBEG.
- "Did you decide 'how many children to have' or did you just decide to prevent pregnancy at that time?"
  - All answered that they used contraception to prevent pregnancy *at that specific time*. They did not use contraception to limit the number of children.
- How did you decide which method to use?
  - Women in the WBEG sample tended to learn about the methods from friends. In Malakal, the few users said they decided based on advice from MTH or ARC's community-based distributors (CBD). A small number said based on information from a friend or from "*an Arab neighbor*" (referring to someone returning from Khartoum or "the north").
- "Was it a joint decision by the couple or is she using it secretly?"
  - Most women have made their decision alone and keep it to themselves. Some explained that since they are the ones suffering, they "just decided." Most women using contraception said they use it secretly because their husbands would not allow it, or they fear their husbands wouldn't allow it.
  - *"If my husband knows about it, he will beat me up."*
  - *"Women do not discuss such things with our husbands. To be sure, I made this decision myself."*

A small minority of women respondents said that the decision of whether and what type of contraceptive to use was a joint decision. In one instance, the couple had had two children in quick succession and the elder one was always sick. For other husbands, the motivation is economic combined with desire for spacing (see the case study of Gabriel, below).

Case Study: A Couple Who Used Pills for Spacing

Gabriel, age 25, Shilluk, is a secondary school dropout. He has one wife and two young children. Like many others in Wau Shilluk village, Gabriel says the main problem is lack of food. Many men migrate for three to four months at a time in order to earn a cash income to support their families. Gabriel feels a special burden as the elder son in his family. He earns an income from making and selling charcoal, along with some agricultural products.

He only wants one wife ("*God created only two people: Adam and Eve*"), but he wants 10 children. Reason: "*Because some will die, but some will remain*." He knows of condoms ("*Can prevent HIV/AIDS*"), but he will not use them "*because I have my wife*."

His wife has used the pill. About a year ago, they decided to use the pill "*to satisfy my need while my wife had a small baby, and to protect from unwanted pregnancy*." They got the pills from the PHCU and also bought them from the pharmacy. Other men in the community did not know they were using pills. They felt satisfied with the method, but have discontinued using it because their youngest child is now 2 years old and they would like a third child.

Contraceptive Continuation and Discontinuation

For persons using contraception, the question was asked: "Are you happy with the method?"

It is not currently possible to get statistically significant data on contraceptive continuation or satisfaction. Some women interviewed in Upper Nile said "Yes" and reported that they had received counseling from the providers and are comfortable with the method. Almost all contraceptive ever-users in the WBEG sample expressed satisfaction with their method. In Mundri, all women who were using the birth control pill stated they are using it successfully. None of the respondents said they would discontinue use of any method because of a health problem.

But interviews in Upper Nile indicated a high level of contraceptive discontinuation. Two reasons were cited.

1. *Intentional spacing*. The woman (or couple) had used contraception for spacing and discontinued after two years or so when they wanted another child. This is appropriate contraceptive use—although a three-year interval would be better than two (see the profile of Nyalum below).
2. *Inadequate knowledge*. Among the small number of respondents who had used contraception, about half said they stopped because they lacked adequate information (see the profile of Elizabeth below).

A Dedicated User of the Pill for Spacing—Who Hides it From Her Husband

Nyalum, age 19, is a Shilluck and married to a Nuer. She became pregnant at age 15, married the boy, and now lives with him, his parents and their daughter who is now 2 1/2 years old. They are returnees from Khartoum (they came back last December). Her husband is a secondary-school student in grade 12.

Her daughter was born in Khartoum. Nyalum began using the pill when her daughter was 3 months old. *"There was a hospital for pregnant women where* dayas *[midwives] cared for young girls and told about the pill. I was 15. The* daya *said, 'If you use the pill, you can continue your education.'"*

Nyalum wants only three children "*because the living situation is very bad*." She has no idea how many children her husband wants. "*We have never discussed this, but here in South Sudan men don't like their wife to prefer fewer children*." He does not know she has been using the pill.

When Nyalum decided it was time to have a second child, she stopped taking the pill and became pregnant shortly thereafter. After this baby is born, she will go back to using the pill. Is she happy with this method? *"Yes. With the pill, you don't get pregnant. I will not stop using family planning ever until I become old [menopausal]."*

Unmet Need: A Woman Who Tried the Pill but Stopped and Had an Unwanted Pregnancy

Elizabeth, age 35, Nuer, in village Hai Telmia, is an illiterate widow with six children, the youngest is 5 months old. Elizabeth married at about 18. Her husband subsequently took two additional co-wives, but has since died. Every day now, Elizabeth fetches grass from the bush to sell, fetches water and firewood, cooks meals and breastfeeds her 5-month-old son. She cites her main problems as sickness, lack of husband, lack of food, and lack of money.

In 2010 she got some contraceptive pills from a pharmacy. She decided to do this because she had no husband to care for her, but wanted "a return of sexual satisfaction/fulfillment" and had a new friend. She says she took the pills only once because she "didn't know the good or bad things about the pills." It was thereafter that she became pregnant with her youngest son.

Elizabeth says she does not want any more children "Because who will help me? The one who gave me the baby never took care of me and the baby." She is not using contraception now.

Condom Use

In Upper Nile and WBEG, most men spoke ill of condoms and very few men said they had ever used them. Those few who said they use condoms, said it was for protection from HIV/AIDS with women who are not their wives. Some include prevention of STIs and

extramarital pregnancy. Condoms are associated with having a sexual relationship with prostitutes. Men who have used condoms generally believe they are not good because they reduce sexual pleasure.

- *"Men don't use a condom with their wife. If the husband suggests using a condom, the wife will think he's treating her like a prostitute. This is a reason 'counting days' is done."*

Staff at WTH and MTH said that they have many condoms in stock, but only a few men come to get them. The same was said at a Jur River clinic and the PHCU in Wau Shilluk. One county official said some NGOs took condoms to the PHCCs/PHCUs in that county but as soon as they left, the condoms were thrown into the latrines.

In Mundri, Western Equatoria, however, there seems to be greater use of condoms. Men's reasons for using condoms included: *"To prevent us from getting an unplanned pregnancy;" "To help our baby grow strong before we have another one;" "We just want to space the children and not have many of them;" and "To prevent both HIV and pregnancy."* Respondents who use condoms said they have no problems with them and are satisfied with the method. Couples agree to use condoms because they are comfortable with them and can afford them. Condoms are cheap in the private clinics and pharmacies and free in the PHCUs and PHCCs. At the same time, many people still view condoms negatively and associate them with having sex with a prostitute. Thus many who use condoms keep it a secret from relatives and the community.

AVAILABILITY OF AND ACCESS TO CONTRACEPTION AND FAMILY PLANNING SERVICES

Availability of Contraceptives and Services

Upper Nile State

Contraceptives and counseling services have been provided in Malakal County since about 2008. Today, they are available as follows:

- *Malakal Teaching Hospital*. On the hospital grounds is a small, improvised site operated by ARC with support from UNFPA. This is advertised on the signboard as "Family Spacing." UNFPA has a large locked RH supply warehouse on the grounds and is said to have good and adequate RH supplies. Through UNFPA provision, the "Family Spacing" site provides pills, injections, IUDs (coils), Norplant II ("Jadelle") and condoms. The nurse/medical assistant at the "family spacing clinic" said many women are now choosing an implant. According to the UNFPA contract midwives at MTH, "*Women love Jadelle—more than the pill, coil [IUD] or injection. But condoms! You can barely get them to leave the shelf!"*
- *American Refugee Committee*. ARC is considered the lead organization for RH in UNS. Since 2008, ARC has been the leader in providing contraceptive and RH services in Malakal County, in conjunction with the RAISE Project of Columbia University. This includes the first community-based distribution (CBD) program in the county. This features outreach CBD workers who go out into communities and homes to promote FP and provide contraceptives (mainly pills).[29]
- *International Medical Corps*. IMC is a sub-contractor under USAID's SHTP-II. It began providing FP "awareness" and services in 2009. IMC provides the PHCU of Wau Shilluk village and other designated PHCUs with support in seven priority areas of RH, which includes FP (child spacing and FP information and services).
- *Primary Health Care Centers/Units.* In principle, all PHCCs and PHCUs are to provide FP services. The extent to which they are able to do so varies. Bam PHCC, in Malakal's Southern *payam*, seems to be among the best. The PHCU in Wau Shilluk village provides pills, injection and condoms. Three women had come for injections in the previous three months and seven women for pills. Condoms are unpopular. In Obel village, the PHCU has no contraceptive supplies—and very little in the way of other medicines or supplies.
- *Pharmacies*. Some carry contraceptives. The research team visited a sample of six pharmacies in Malakal town. Three had some contraceptives; the other three had nothing. Sales clerks in all six said they have customers asking to buy. They would welcome supplies.

[29] ARC has just conducted an "End-line Survey" covering its FP project. The results of that study will be important for any program development on child spacing, FP and RH in Upper Nile State. CBD workers are also a major element of a new activity that Marie Stopes has launched in Juba and in Bentiu.

Mundri, Western Equatoria

The majority of rural respondents do not know where to get contraceptives, although they are being provided by various sources. Contraceptive pills, injections and condoms are primarily provided by UNFPA and community-based organizations (CBO) and NGOs, such as MRDA; Action Africa Help-International (AAH-I); FHI; PSI and OXFAM. These include USAID-funded projects operating in Mundri.

Currently, the MRDA, a local NGO operating in Mundri East and West offers contraceptives. Mundri Relief and Development Association is a subcontractor of USAID's SHTP-II. The demand for contraceptives (mostly pills, condoms and injectables) is low. However, in Western Equatoria, some educated urbanites seek contraceptives to space their children. Beginning on September 15, 2011, FH1 360's Sudan HIV/AIDS Project (SHAP) has incorporated integrated FP services in Mundri East and Mundri West counties, running simultaneously with HCT and condom distribution. Health facility staff is trained on modern contraceptive methods, but supplies have not yet been distributed for Mundri East and West HFs.

In West and East Mundri counties, MRDA and Action Africa Help-International have been providing contraceptives since the year 2005 and 2010 respectively. Some of the PHCCs and PHCUs also provide these methods of contraception, with most supplies coming from MRDA. But often, PHCCs do not have a supply of contraceptives. As a result, some people go to the health centers but their need may not be met because contraceptives are not available. Some private clinics and pharmacies in Lui and Mundri also sell contraceptives.

Western Bahr el Ghazal

Respondents said they got FP information from WTH, midwives, and mostly in PHCCs/PHCUs in Wau County only. In the communities visited in Jur River County, no information is currently provided about FP or contraceptives.

Respondents said contraceptives are available at WTH, pharmacies, PHCCs, PHCUs and private clinics. The most common sources for respondents are private clinics and pharmacies, though several get them from clinics supported by SHTP-II (available since July 2011). Areas visited in Jur River County do not appear to have contraceptives (aside from condoms which, as noted, do not seem to be used much for contraception). WTH does not officially provide contraceptives, but some respondents indicated that midwives there do provide some. It appears that PHCCs and PHCUs (aside from those supported by SHTP-II) do not provide contraceptives other than condoms.

John Snow, Inc., a local implementing partner under SHTP-II, noted that it has requested and is waiting for mini-pills, but that COCs, Depo-Provera and condoms are available in at least four of the clinics it supports. If there is demand, women can get IUDs as well. The JSI respondent also noted that midwives encourage couples to come together, and that they plan to use village health committees to reach out to men.[30]

"Awareness:" Introducing the Idea of Family Planning and Basic Information

Some "awareness" events have been carried out in all three states to introduce and make people aware of FP and contraception. An example is the *"Family Planning and HIV Awareness"* event sponsored by IMC at the Friday market in Malakal in January 2011, the first ever in that market. The sponsors distributed 100 boxes of condoms and estimated that some 3,000 persons received the messages about FP and HIV in Dinka, Nuer and Shilluk languages.

[30] Very little was said about storage of contraceptives. Only at Malakal Teaching Hospital did the UNFPA contract midwives there show their contraceptive warehouse and comment on its good supply.

Access

Access to contraceptives is very poor. Most people in these states live far from any hospital, PHCC or PHCU. While pharmacies may be closer, many lack a reliable supply of contraceptives and sales clerks have little accurate knowledge about contraceptives.

Community-based Distribution (CBD)

In Upper Nile, the CBD outreach workers of ARC are praised for getting out into the communities and providing awareness and contraceptive pills to women and couples. ARC is a respected pioneer in this regard; it is the first organization in UNS to train and deploy CBD workers.

At the same time, some respondents indicated that the CBD workers do not provide the needed follow-up counseling and information for women who have questions about the method—and that other sources of provision are unknown or too far from home for women to reach. CBD workers thus seem to be a mixed benefit: they raise awareness and interest and supply some women with contraceptives, but may not be able to give adequate information for women to become "satisfied users."

One FGD concluded that contraception should be provided only in medical facilities such as the hospital or PHCC. *"If it is available outside health facilities, it may be misused. Nobody will make sure that it is used in the proper way."*

"DEMAND" AND UNMET NEED FOR CHILD SPACING AND FAMILY PLANNING

"Demand" for Family Planning is Negligible

"Desire" or "demand" is hard to measure or even estimate. But, by any measure, stated *"desire" or "demand" for family planning* is minimal in all three states. As detailed above, many people are hostile toward the idea. Several men commented: *"We lost two million people in the civil war. We do not need family planning!"*

Evidence of Unmet Need for Help in Child Spacing

In contrast, there is substantial unmet need for and interest in using contraception to space children. Service providers in all three states said that unmet need is very high in urban areas and in some of the villages. Evidence exists in the interviews with young women, or couples, who said they are using or have tried using contraceptives. While the numbers are low, all stated that for the goal is child spacing. Further evidence exists in the statements of women who would like to use contraception, but have not had access or adequate information. Additional evidence exists in the apparently increasing frequency of induced abortion.

Further, some rural women encourage their husbands to take more wives (so that they, the first wives, can rest from having children), some going as far as bringing girls home to ask their husbands to marry them. (From the Western Bahr el Ghazal report.)

Great Interest in Spacing with Minimal Ability to Do So

Local populations in all three states continue to believe in the importance of child spacing and show growing interest in the use of "modern drugs" (contraception) for this purpose.

Unmet need is high among women in urban areas and somewhat high for women in rural areas. Many women expressed great interest in spacing their children, with minimal ability to do so. Too many find themselves pregnant less than a year after giving birth. Among other consequences, this means the mothers must prematurely stop breastfeeding, which dismays many. Many women openly expressed being tired; finding it difficult to manage so many children; or wanting a rest from having children. In the case of older mothers interviewed, they wanted their daughters to space their children so that they, the grandmothers, would have less children to care for. In Upper Nile, many women still seriously adhere to the traditional requirement of abstinence, now shortened to two years. In Mundri, many respondents mentioned frequent pregnancies occurring among couples who did not want a child at that time.

Desire to Learn About—and Use—Modern Methods for Child Spacing

Many women interviewed indicated that they would like to learn about modern methods of child spacing. The response of a 29-year-old woman in Malakal is representative:

> *"I want to know more about the modern methods to make spacing while having sex with my husband but not getting pregnant…I need more children, but now I have a small child. I don't want to get pregnant until the child reaches 2 years."*

Most of the nine women in one FGD said they had heard of modern drugs for child spacing but had not considered using one "*because we have no information."* Participants agreed: "*If we know where we can get it, we could try it so that we can manage child spacing for three years between children."*

In Wau County, when respondents were shown a WHO flipchart presenting each contraceptive method, positive interest increased immediately. People wanted to know more about the methods and one group of women asked the research team to attend a follow-up meeting to explain the methods to another group of women. Several respondents said they wanted to start *using* a contraceptive method after learning more from the flipchart. (See the case study of Joy, below.) In Mundri, many rural female respondents admitted their ignorance of modern contraception methods. After FGDs, several said they wanted to use one of the methods, if available.

"Unmet need" refers here to women or couples who do not want another child at this time, but who are not using abstinence or contraception.

As a note, religion does not appear to stand in the way of these women, including those who are Catholic.

A Case of Unmet Need in Bussere, Western Bahr el Ghazal

Joy, a Balanda woman, who is joyful like her name, wasn't sure of her age but is probably around 34 years old and lives in Bussere village in Wau County. She is married with nine children and pregnant with another.

Joy got married at the age of 15 and her firstborn is now 19 years old. Her parents decided on her marriage. She is a single wife to her husband and, like other women, spends most of her time in the garden cultivating crops or doing other domestic work such as cooking meals, washing clothes, and caring for children.

But Joy's joy fades as she tells us her problems. "My major problem is breastfeeding and carrying pregnancies every year. Each time my babies get to 5 months old, I find myself pregnant even without seeing my periods. I don't like it, and I really feel tired and exhausted of childbirth."

When asked the meaning of family planning, she said she did not know and had never heard of it. Interviewers showed Joy the WHO FP flipchart, and Joy exclaimed: "You people, why you have made me suffer like this and yet there is a solution to my problem? I am starting contraceptives right away. Can you inject me now? I wish I knew it before…"

Joy said she would not discuss it with her husband because he will not agree with her and, since she is the one suffering, she will go for injection alone immediately.

Case Study of Unmet Need: A Pragmatic Upper Nile Woman Who Wants to Use "Drugs," But Doesn't Know Where to Find Them

Nyabil, 24, Nuer, with three children, struggles with poverty. She brews local alcohol to secure money for food and medical care when her children are sick. Nyabil wants [only] six children "because if I have very many I will not manage to educate them and they may become thieves." She would like to "take a rest from having children, because, even with the children I have, it's hard to feed them."

Nyabil has heard from an Arab neighbor that there are drugs that prevent pregnancy. She explains what she knows: "In our traditional child spacing (meaning postpartum abstinence), the husband can force the wife to have sex and she can get pregnant. But with those drugs, even if you sleep with the man, you don't get pregnant…I would use these drugs, but I don't know where to find them."

The Economic Factor

Increasingly, many men in urban areas and some in rural areas said that it is difficult to feed and educate too many children. These men—who generally have some education—express openness to the idea of using a modern contraceptive method. Some of them have supported their wives in trying a method (as in the case study of Gabriel, above).

Educated men in an FGD at the Upper Nile Ministry of Irrigation said many in the community would like services to help them space births. Their reasons: "*To let the baby's health be good;" "To avoid sickness in the children, because the longer the baby breast-feeds, the better it gets immunity;" "Spacing the children gives the woman strong health;" and "Economically, with limited resources and income, it has a positive impact."*

View from the Pharmacies

Brief interviews with staff at six pharmacies in Wau revealed that requests to buy contraceptives are increasing every day. Pharmacies sell pills, injectables, and condoms. Staff said most women request pills, and they get between five and eight pill customers per day. In Malakal, several

pharmacies visited said they lack contraceptive supplies to meet demand and would like to have such supply.

Abortion Trends

Abortion was traditionally very rare, considered a sin against God. Today, however, abortion has become more common and there is greater acceptance of abortion among those who value education. "*Girls who want to continue their education may choose abortion*."

Some respondents in Malakal said that today if a school girl (secondary or university) gets pregnant, she follows one of two courses. She may withdraw from school to have the baby, whom she then gives to her mother to care for while she returns to school (and remains single). Or, she has an induced abortion and continues school. Staff at MTH said there are "many abortion cases" in the ward—some spontaneous (especially due to malaria), but many induced. They cannot estimate the proportions, but believe induced abortions are becoming more common.

In WBEG, many respondents, especially in urban areas, had heard of women having induced abortions—mostly young girls, but at least one or two married women. But in rural areas too, two providers said they were aware of induced abortion taking place in their communities. One respondent had two friends in Khartoum and one in Wau who died as a result of abortion. One woman said her husband gave her a quinine overdose to abort the fetus, but it did not succeed. Other methods mentioned include aspirin overdose, battery acid, IV drip tube, honey and water (two to three women), and drugs from the clinics or pharmacies. One woman in her thirties admitted that she sought an abortion at a clinic when she became pregnant with her eighth child. She said her youngest was just 5 months old, and she was tired and did not expect to get pregnant. When she inquired about abortion at the clinic, staff referred her to WTH. A doctor there threatened to take her to the police because abortion is illegal.[31]

Cases have recently been reported from Juba of young women drinking a mixture of "Omo" brand soap powder and gasoline to induce an abortion and dying instead.

What Kinds of People are Most Interested in Using Contraception?

Consensus from interviews and the FGDs concluded the following:

- Women more than men.
- Younger people (30 and below) more than older.
- Urban people more than rural.
- People with at least primary education and especially those with more than a primary education.

More educated women tend to have both fewer children and greater interest in using contraception. The Mundri data (Western Equatoria) collected for this research were analyzed using the statistical program SPSS to study the relationship between the variables of education and number of children.[32] The data show clearly that women with higher levels of education tend to have fewer children. (The results were inconclusive for men as there were not enough men in the study sample for the relationship to reach significance.) Women who expressed the most interest in using contraceptives are married women/girls (ages 15+) who are educated or

[31] It is the understanding of USAID/South Sudan that there is no legal position on abortion under South Sudanese law. Many medical practitioners, however, apparently believe it is illegal or otherwise treat abortion cases as if it is illegal.

[32] It was not part of the study design to conduct statistical analysis of the data (neither funds, nor time were allocated for this purpose). It was the personal initiative of Dr. Stolba to use SPSS for Mundri data.

in school, women with complications, such as having previously delivered by Cesarean section, and women with high parity.

Western Bahr el Ghazal respondents overwhelmingly said that *married urban women, educated people, and school-age girls* are the ones most interested in using contraceptives.

Adolescents were not included in this study (as per request from MOH and USAID). However, evaluation research concurrently conducted in UNS on the ARC FP pilot activities found adolescent openness to contraceptives:

> *"Overall, adolescents were the keenest group motivated to learn about contraceptives. Girls especially seemed to understand the consequences of unwanted pregnancy and were eager to continue their education; hence, while some were shyer than others, they all appeared interested in learning about existing options, especially non-invasive methods. The most popular method was the calendar method, as recurring concerns were fears of condoms becoming stuck during intercourse."*
>
> *"One noticeable comment regarding contraceptive commodities in a setting such as Malakal was the risks of sexual assault." One adolescent girl stated, "It is good to contact the parents and to continue coming to this school to tell us more about the methods. If there is insecurity in the area, crimes happen…The boys wait to rape girls on the way from church. If that will continue, we girls suffer a lot."*
>
> *"Both girls and boys eagerly requested that family planning be formally integrated into their education. Regardless of school or church restrictions, the FGDs reflected a clear interest among students to learn about and access contraceptive options."* [33]

Do Many People Want to Limit the Number of Children or End Childbearing?

Very few respondents said they want to limit the number of children. The few who express interest in limiting or ending childbearing are most commonly those who already have four or more children and who feel economic pressures. For example:

- A woman with four children wants no more. She is one of five co-wives. "*The husband does not take responsibility for my children. I cannot manage more."* (Many women complain that their husbands do not take enough responsibility, and want fewer children for this reason.)
- A man with three children said he wants only four. Reason: "*My resources are limited; I want to provide their needs*."
- A man with two children said he wants only three. *"To be able to provide them the best thing they want."*
- A young woman with one child, wants only three *"because I want to go back to school."*

[33] American Refugee Committee, Centers for Disease Control and Prevention and Women's Refugee Commission. "Summary of Preliminary Findings: Qualitative Research from Community-based Distribution of Family Planning Pilot." Draft, October 2011, p. 3.

A few people in WBEG talked of limiting births, especially in urban areas. Some women and men said they had enough children, and one woman was sterilized after deciding three children was enough. For women in Jur River and some in Wau County, the preferred solution seems to be to abstain from sex. For women in particular, the main reason for sex seems to be procreation.

Case Study: A Couple that Wants to End Childbearing

One Catholic father of seven in rural Wau County said that his father had nearly 40 children, and what he, the respondent, learned from that was that fewer is better. He and his wife would like to stop having children because feeding and educating so many is difficult and stressful. He strongly values education and wonders how his children will go to university. His father was only able to send one child to university and the respondent regrets that it was not him.

What Contraceptive Methods Are Likely to Be Most Popular?

Pills, followed by injections, are currently the most preferred methods in all three states.

Personnel at MTH also reported that pills are most popular, followed by injections and then an implant ("Jadelle"), which is rapidly becoming popular. As noted above, according to the UNFPA contract midwives at MTH, "Women love Jadelle—more than the pill, coil [IUD] or injection." Condoms are said to have no immediate future for contraceptive purposes (although they may become used by more open-minded persons). As one medical assistant said, "*No, no, no! A condom is not a contraceptive. It has a different purpose—protection against HIV/AIDS*."

In Western Equatoria, methods likely to be popular are injections, pills, natural methods (LAM and Standard Days Method [SDM]), and condoms.

In WBEG, pills and injectables are by far the most popular modern methods. One female respondent said she uses an IUD (inserted in a neighboring country). Given the strong tradition of abstinence and some mentioned of the use of "safe days," the SDM with CycleBeads could be a highly desirable option for couples who fear side effects of other methods.

BARRIERS TO CONTRACEPTION AND FAMILY PLANNING

Many barriers stand in the way of contraceptive use. Some are cultural, some are cost-based, and others are fear-based.

Men

Women reported that their husbands are the barrier to contraceptive use. By and large, men in rural and urban areas alike do not like the idea of contraception and FP. Many men think that modern methods will permanently stop women from getting pregnant.

By far, the greatest cultural barrier to contraception is the dominant belief by men that it is best to have *"as many children as possible."* This supports a culture that dictates that the purpose of women and marriage is to produce as many children as possible. A women's focus group emphasized: *"Men don't agree with long child spacing (three or four years), because they believe that they paid the dowry and so they want more children."*

- *"Men are the main cause of problems in the family, because if you refuse to have sex with them, they can beat you up."* Hai Telmia, UNS, FGD with young women.
- *"I've heard there are drugs that prevent pregnancy. I would like to use these drugs. If I do use, it will be secretly because if my husband knows it will create problems."* Agijah, 24, Nuer.

The gender specialist working with ARC in Upper Nile, a consultant from Uganda, judged that gender-based violence is much worse in South Sudan than elsewhere, and emphasized that this is a serious barrier impeding women from using contraception for child spacing. Interviews in Mundri found husbands who beat their wives and justify it with claims such as, *"They are committing adultery if they are using contraception."*

Desire for Many Children

Advantages of Many vs. Fewer Children

Interviewees were asked "What are the advantages of having many children?" and then "What are some benefits of having fewer children?" The reasons given are important for program planning.

Most rural people see many children (8, 10, 20 or "as many as God will provide") as most desirable. Urban people, especially with more education, tend to see fewer children as better. They express this, however, with numbers such as "I only want six children." Some respondents also said "*God decides*."

One cultural belief is that many children *are needed*. The principal advantage cited is the uncertainty related to high child mortality. "*Some children will die; some will remain*" is by far the most common response. In Upper Nile, many expanded on this with answers such as: "*Some children will die; some will remain. Some children may grow up educated, some may take care of the cows, and some may become thieves, criminals, and prostitutes."* Respondents who gave this reason explained that not all children can be educated and that, almost inevitably, given widespread poverty, some would resort to petty thievery and even criminality (*saluk)*.[34] Thus, in order to have a few good children, it is necessary to produce many.

- A Nuer woman, age 29 with three children, wants 10 children. *"I need more children. Some of the children are going to be responsible which can assist me, but others will not be successful. With 10, I will not be a loser at the end."*
- A peri-urban FGD concluded*: "Not all the children will be good luck. Some may be leaders and others criminals. You don't know who among them is going to be good, so you need to produce more."*
- An older man in WBEG explained*: "I had 18 children, and 9 of them died. What if I had only had two or three?"*

Other reasons given for why it is better to have more children included:

- *"More children give higher status in the community."*
- *"To expand the family."*
- *"To fill the gap left in the family by their parents who died and are missed."*
- *"The more children you have, the richer you become. If you have many girls, you get paid many cows."*
- *"For protection, in the case of fights between clans, families, etc."*
- *"If you have many children, others will be fear to come to your family to raid cattle."*
- *"To become a royal family."*

[34] It is reported that bands of armed and jobless "criminal" youth now make a living raiding and subsequently selling stolen cattle (International Crisis Group, October 2011). This may be what parents fear.

Data from one representative FGD illustrate the uncertainty associated with child mortality (see Table 8). Among these 11 women, all had experienced the death of at least one child, while six of the women had experienced as many as three or four of their children dying. For two of the women, half of their children died.

These data also show that the majority of these women have at least one or two co-wives. Everyone interviewed and in the FGDs identified themselves as Christian, but religion does not appear to have had much influence on the common practice of polygamy.

Table 8: Child Death and Co wives Both Common

FGD Participant	How many children were born to her?	Of children born, how many died?	She has how many co-wives?
01	10	4	2
02	10	2	1
03	10	4	0
04	8	3	4
05	8	2	1
06	8	4	2
07	8	3	2
08	8	2	2
09	7	2	0
10	7	1	0
11	6	3	1

People who want fewer children all cite economic reasons. "Fewer" generally means four, five, or six children, typically expressed as "only four" or "only six." Respondents reported that their income is limited and living costs are getting more expensive. They want to provide their children with good/nutritious food, provide treatment for sickness, and send them to school. As expressed by a young woman in Wau Shilluk village, *"It is not easy to educate all children. If you have a relative in town, you can give some children to that relative. But you can't afford to pay school for all."*

As noted above, many people believe that if they have many children, some will be irresponsible, even thieves or "criminals." Thus, a second reason for having fewer children is to raise successful children: *"To be able to control them." "To manage to educate them properly." "To manage to bring them up in a good manner." "To prevent the children from going out to the streets."*

Some men are unrealistic about their ability to support many children. One peri-urban man with 6 children said he would like 20 children. When asked by the interviewer how he would educate them, he responded *"I will sell my cows and charcoal to get money for the school fees."*

Other Cultural Barriers and Influences

Private and Secret

Many interviewees emphasized that contraception is a very private matter, not discussed in public, rarely discussed within the family and, for many women, not even discussed with the husband. Among the women who choose to use contraceptives, many do it secretly.

The question was asked "If a woman or man wants to use contraception, or modern birth spacing, who do they discuss it with?" Young women's FGDs reached the following conclusions:

- *"We could not discuss it with our husband because you cannot look for problems."*
- *"The women will not discuss with any person. Discussing with someone is like killing yourself, because it will reach the husband and that will bring problems for the woman."*

Men had a slightly different view. The consensus from an FGD with men was:

- *"We can discuss with doctors and specialist persons. Also the couple can discuss it among themselves. But it cannot be shared with anybody else because it's a secret thing."*

Another barrier, most relevant to rural populations, is fear of being openly known in the community as an individual who uses contraception. Many respondents said the community would stigmatize a woman who uses contraception.

Misinformation and Fear

These are formidable obstacles, as detailed above.

Geographic Barriers and the Poor Health System

Geography is a tremendous barrier, especially for women and men in remote rural communities. The lack of paved roads impedes progress in *all* basic health care system strengthening. This is especially true during the rainy season when dirt roads turn to mud and are often impassable by vehicle. The lack of good health services in the rural areas impedes the spread of information about contraception, as well as extension of health services. In many rural villages, most women have heard nothing about contraception or FP.

Cost/Perceived Cost

While the cost of contraceptives themselves is *not* often mentioned as a barrier, the cost of traveling long distances to access contraceptives is a major barrier for rural women. Contraceptives are generally free in facilities where they are available. At pharmacies, the cost is low: four pounds (4 SSP) for a one-month pill supply; one pound (1 SSP) for a strip of three condoms. Some Mundri respondents said they would have used birth control pills, but that the pills were too expensive, especially if purchased from the private clinics. None of them could tell how much they cost.

Community Members Who Are Barriers to Contraception and Family Planning

Men

As stated above, women consider men a major barrier.

In WBEG, researchers asked if there were specific community members who stood in the way of modern family planning (or were likely to). One religious leader was said to have told the village men that FP was dangerous. As noted above, a women's leader in one Jur River community warned that no one should try to bring modern methods to her village. In one group of service providers, mothers-in-law were mentioned as an obstacle—wanting to keep their daughters-in-law away from clinics for fear they might obtain contraceptives. There are people in every community who are against modern FP. Some service providers expressed beliefs—such as methods being unsafe or that only certain types of people use them—that suggest they themselves might act as barriers. Aside from husbands and service providers, it is not always clear who does or doesn't have the power to prevent use of modern methods.

Parents and Parents-in-law

Parents and in-laws of the current childbearing population do not appear to be a barrier. They mainly said, "*We don't know about these matters*." Parents who live in villages said they have no idea, once their children have left the village and gone to Juba or elsewhere, what their children are doing. This was emphasized especially in the context of postpartum sexual abstinence.

Local Community Leaders

Findings are mixed, with local leaders supportive, neutral, or against modern contraceptive methods. This appears to be due to the "awareness" exposure that leaders have or don't have.

Most are not informed about benefits of contraception for child spacing and the health of women and children.

Village Leaders

Five village leaders were interviewed in Mundri West and East. They occupied the following positions: *Payam* Chief, Executive Chief, Community Leader, and Elder. They cited girls getting pregnant at an early age as one cause of maternal mortality. They identified child spacing as a good idea because of the following: *enables the mother to look after a child properly; enables the mother to regain her strength;* and *reduces the death rate among children under age 5*. All five leaders supported educational programs to promote child spacing.

In Upper Nile, the study did not find that *village leaders* themselves act as significant barriers, but rather it is their ignorance of the benefits of contraception. Village leaders, it is said, rarely speak on health matters, and never on contraception or modern birth spacing. The research team met two village elders, who were ignorant about contraception and thus against it, and one progressive village chief.

A Village Chief Speaks Out for Village Education on Child Spacing

Sultan Ngundeng, a village chief, has 6 wives and 19 children. But he is progressive when it comes to his villagers. To help reduce maternal mortality, he says women should eat well and go to the hospital for checkups during pregnancy. He thinks it's a good idea to space children "because the baby can be strong when properly breastfed." When asked, "What is family planning?" He answers, "It's medicine to organize the family. It's a good thing if government can bring it here." This is the first time anyone has come to his village to talk about health issues and he welcomes more. "To do awareness to both men and women like you are doing. Organizations should come and study the views of the community and take those views to the government."

Religious Leaders

In Malakal, there was no evidence that religious leaders act as a barrier; two experiences illustrate this. At a Dinka service at the Evangelical Church of Sudan, the pastor welcomed the research team to come to the front of the congregation and speak about the study, after which he called for parishioners to come together after the service to participate in a FGD. The second encounter included an Anglican bishop who emphatically spoke of child spacing as essential in this time of rising costs and difficulty making ends meet. He welcomes any NGO or other group that can speak *knowledgeably* about contraception to come to his parish and speak about contraception and child spacing.

In WBEG, where Catholicism has the largest following, interviews at a Catholic hospital and with a village catechist indicate openness to modern methods. The catechist was fully supportive of modern methods for both spacing and limiting births. And while the hospital matron expressed a preference for natural methods, she teaches nursing students about modern methods as well. She also stated that the fact that many women are seeking to terminate unwanted pregnancies is evidence of high unmet need. She said that methods should be available so women can choose. A second religious leader interviewed was completely against modern methods. In Mundri, some religious leaders speak against contraception and FP because of the common belief that having a child is a gift from God and that people thus should not prevent pregnancy.

Local Politicians

The study in Western Equatoria found some politicians against the use of contraception. These community politicians speak publicly against contraceptives and discourage community members from using them. Some politicians maintain that child spacing reduces the number of people in their constituencies, which may cause them to lose out on distribution of services by the national government.

Deaths During the Civil War

A common reason given for opposition to FP and contraception is that the civil wars have killed many people. South Sudan, in the mind of many individuals, needs to increase its population.

SOURCES OF INFORMATION, INCLUDING HEALTH INFORMATION

Respondents said they commonly get information about current events and services available to them through public announcements via microphone. (Someone driving through the community making announcements from a moving vehicle with loudspeaker, such as "Sultan Jambo," a figure in Equatoria.) Other important sources of information include radio, chiefs, church, and community gatherings such as funerals and markets. Some also mentioned posted announcements. Although only a few own radios, many have access to them. Hardly anyone owns or has access to televisions. Newspapers and magazines are generally not accessible and none of the respondents mentioned reading newspapers. (One service provider offered: "South Sudan does not have a culture of reading.") Many in the urban areas and some in rural areas have cell phones, but they have difficulties accessing a network. No one said they get information via text message, because most are illiterate or have very little education. Of the few literate people, many have laptops and get news from the Internet.

Sources of Information about Health and Contraception

Health facilities were commonly cited as the best places to get information about health matters and answers to health-related problems. Most said they get information from the local hospital, the PHCCs/PHCUs, health workers and occasionally radio. The other places mentioned above were also applicable. Microphones and megaphones are often used in the streets to announce and encourage immunization. Very few said chiefs discuss health matters with their communities.

Information about Contraception/Family Planning

Most respondents who have gotten information about contraception/FP said it was at the local hospital. A few mentioned the PHCC or PHCU or occasionally friends, relatives and neighbors. In Upper Nile, the most commonly mentioned sources of information about contraception are CBDs of the ARC family planning/RH project and Arabs/people from the North. In WBEG, most respondents who know about contraception said they found out about it from friends, a PHCC/PHCU, or from living in other places (for example, Khartoum or Central Equatoria). In urban East Mundri, the few respondents with good knowledge of contraception had acquired it through the MRDA, which provides FP services in the area. Other community members said they sometimes get information from PHCCs/PHCUs, primarily during ANC visits, and from MRDA and Action Africa Help-International (AAH-I), which occasionally conduct FP/health awareness sessions and training workshops. In Mundri, some young people mentioned receiving information in schools.

Asked where they would like to get health-related information, most respondents mentioned the hospital, PHCC/ PHCU, public announcement (megaphone or microphone), or radio. Some added from their church or chief. A few suggested it would be excellent to discuss contraception and child spacing on "Miraya FM," a call-in talk show from Juba.

Awareness Events

Community "awareness" events introduce contraceptive methods and the concepts of FP. Very few respondents mentioned participating in an "awareness" event.

An example is the "Family Planning and HIV Awareness Campaign" conducted at the Friday market in Malakal in January 2011, the first ever in that market. Sponsor IMC distributed 100 boxes of condoms and estimated that some 3,000 people received the messages of FP and HIV in the Dinka, Nuer, and Shilluk languages. [35]

PERSPECTIVES OF HEALTH CARE PROVIDERS

Health service providers (including managers and directors) have somewhat different views from the general childbearing age population, but they are fairly well aligned. This is especially true for midwives and CHWs. Urban providers are also more socialized in the FP paradigm, as compared to community members in general, and have fewer negative or incorrect views. Providers in the villages, however, are less knowledgeable and some may be giving erroneous advice. Female providers, in general, appear more attuned to women's needs.

Providers believe they are doing a good job given the very poor infrastructure and available resources. Yet many are highly frustrated about not being able to provide more and better services that encompass child spacing and FP. Providers are all concerned about their lack of what is needed for RH services and reducing maternal mortality: equipment, midwives, drugs, and labs. In some communities (e.g., Obel village) the situation is dire with a single stethoscope being the only medical equipment.

Across perspectives—from County Health Director to the UNFPA contract midwives—the plea is to increase the numbers of qualified midwives (and assure that they have all basic equipment and medications). This is the consensus of all providers and managers interviewed.

As in many countries, participation in training workshops is highly valued, but does not seem to be evenly spread throughout the provider population. Efforts are made to link one training with another, in terms of using knowledge and skills across health topics to improve overall service delivery. For example, many of the same midwives have participated in workshops on FP, HIV, EPI, infection control, and reduction of maternal and neonatal mortality. At the same time, some managers (e.g., the SMOH in Upper Nile) emphasize that training events are not well coordinated and that many end up being duplicative and redundant.

For the most part, providers seem to have good relationships with the communities they serve. In WBEG, most interviewees spoke fairly well of public health service providers, especially in Wau, Bussere and Angisa. (Service providers, including state and county government workers, organized the recruitment of most of interview and FGD respondents. Abou was the main exception, which was organized by community volunteers in a Red Cross program; several Wau interviewees were identified by the research team; and a Wau neighborhood chief recruited men for one FGD.) In Jur River County, service providers and community members expressed great frustration and lack of faith in government regarding their access to the information, infrastructure, supplies, and other support needed to provide adequate health services there. The research team heard many calls for NGOs to provide commodities, new facilities, and trained staff, noting that: "NGOs keep their promises."

Overall, service providers in WBEG expressed that unmet need for FP/contraception is high. Providers' opinions of what others thought of FP—usually that it means limiting births and it is

[35] International Medical Corps, "SHTPII 2nd Quarter Report 2011," p. 6.

not desirable—did not quite match what community members told the researchers. Some of this could be a language issue, in terms of how "family planning" and "birth spacing" were translated (and then explained so the discussion could continue even if respondents had not heard of either).

In Western Equatoria, providers also said that unmet need is considerable, despite many negative comments from community members about FP and contraceptives.

INCREASING CHILD SPACING AND USE OF CONTRACEPTION: PARTICIPANTS' RECOMMENDATIONS

Best Approaches to Encourage People to Try Modern Contraception

Participants (respondents and providers) in the study were asked: "Given the findings above, what approaches might best encourage people to try modern contraception/family planning?" Their most common responses were:

- Emphasize child spacing because everyone wants this and most do not understand or want family planning.
- Awareness should be done to sensitize both leaders and men and women on the importance of modern contraceptive methods for child spacing.
- Contraceptive methods should be supplied free of charge.
- Improve the health facilities and staff.

Training for Community Leaders

Many respondents said it is essential that training workshops be conducted to build knowledge and support among community leaders. Some emphasized the importance of first educating community leaders. When they are able to better understand and practice birth spacing, then they can encourage their people to do likewise. Community leaders should be trained and educated about contraception through workshops, meetings and radio programs. These efforts should be tailored to the leaders, acknowledge their values and concerns, and build on their interest in having healthy and economically secure communities.

- From a women's FGD*: "Conduct training workshops to create awareness among the leaders on the importance of child spacing. Discuss the benefits of child spacing. Discuss how the traditional way of birth spacing is getting lost. Discuss use of modern methods for good child spacing. Emphasize the role of the husband in supporting his wife in this."*
- From a women's FGD in Wau Shilluk: *"The community leaders will not encourage modern contraceptive methods unless respect is shown for the traditional way of child spacing. Also, the leaders must be told about the cause of women's death during delivery, which has a relationship to child spacing."*

Capacity Building for Service Providers

Engage service providers, including village midwives (TBAs) and village health workers, in discussions about healthy birth spacing; perceptions of modern contraceptive methods (including fears, myths, misinformation, and prejudices; perceptions about the need to repopulate the country; the negative impact of closely-spaced births; and the difficulty of providing food, health care, education, and employment for a too-rapidly growing population at the family, state and national level.

The MOH, SMOH and foreign donors should work collaboratively to create awareness about child spacing and RH.

Awareness and Capacity Building for the Community

Most respondents (both rural and urban) identified the importance of creating awareness of modern contraception through training sessions and workshops on child spacing and RH. The goal should be awareness activities among *both* men and women to expand knowledge and create acceptance among husbands that child spacing is important for the health of both mother and child. Awareness should:

- Link modern contraceptives to the long tradition of spacing children by abstinence and exclusive breastfeeding. (Contraceptives can help maintain the tradition when abstinence becomes impractical because of urban living conditions or other factors.)
- Primarily focus on educating men.
- Consider mobile awareness and clinics to reach rural areas.
- Involve religious and political leaders in awareness campaigns (those who have been sensitized and are supportive).
- Announce awareness events through public information means at the county level or *payam* PHCC.
- Convey messages through radio programs and drama, using local languages; use theater, posters, films, shows and public speeches in churches, markets and health facilities (for example, during ANC visits).
- Promote and educate on the benefits of birth spacing for healthier children and healthier mothers to raise those children ("smart growth").
- Train and employ local people—including men who support spacing via modern contraceptive methods—to do promotion, education, and counseling.

A FGD with employed urban men said that community awareness should focus on the role of men in child spacing. This, they said, should include:

- *"To converse with the wife about child spacing."*
- *"To know the period of the woman, when it started."*
- *"To have sex with the woman in a safe period."*
- *"Better, however, to use a contraceptive method after getting advice from the doctor."*

Contraceptive Supply

There should be free supply of contraceptives. Along with creating the necessary awareness, contraceptive supplies must be reliable. It is essential to adequately supply PHCCs and PHCUs, so that women who are interested have access. Some PHCUs and PHCCs in Western Equatoria are said to have contraceptive/FP services, but not enough to meet the need of the population.

Role of Government, USAID and Other Agencies

Recommendations for Government, Ministry of Health and State Ministries of Health

When asked "What can *government* do to help couples who want to space births?" participants focused on overall improvement of the health system and facilities.

Improve Health Facilities and Services:

- *"Government needs to put health as the first priority. More budget needs to be added for the health sector."*
- *"Improve health facilities." Laboratory services should be introduced in all PHCCs and PHCUs so women don't have to travel long distances to the hospital. Some suggested the construction of bigger*

and well-equipped health centers/units that can provide ANC, as well as contraceptive/child spacing/family planning services.

- *"Provide funding that specifically supports reproductive health services, including child spacing. This should include training staff, construction of health facilities, and supplies needed to provide services.*
- *"Strengthen the capacity of health care workers. Train medical personnel. Provide more midwives. Motivate people who are working in the health field.*
- *"The government should really work hard to bring us water and a good hospital."*
- *"Supply health care facilities with drugs."*
- *"Build more health care facilities and health training institutions."*
- *"Provide health educational sessions about contraception during antenatal care and immunization visits."*
- *"Provide community health workers with transportation to reach distant communities."*
- *"Provide supplementary food assistance to malnourished mothers and provide contraception education along with the assistance."*
- *"Improve the working conditions of the health staff by building staff quarters around the PHCCs/PHCUs and paying their incentives/salaries regularly."*
- *Train pharmacists to provide accurate information about contraceptives and to inquire about possible contraindications* (see Appendix D, which illustrates the interest of some pharmacists in being trained).

In addition to improving health facilities, respondents urged the following:

Improve the Road Network

In addition to improving health facilities, respondents said the government must improve the road network so that people can get to the health facilities. Rural respondents in particular said this is crucial, along with providing emergency transport, such as ambulances and boat ambulances, to help women who suffer from obstructed labor and those who live far from facilities.

Include Reproductive Health Education in the Schools

MOH should work with the Ministry of Education to include RH and HTSP in the school curriculum, especially in secondary schools. While the research team did not interview people younger than 18, many respondents (parents, community leaders, and service providers) recommended educating young people about contraception. This was strongly suggested by service providers who are concerned about the increasing rates of accidental pregnancy among school girls.

Make Safe Water Sources Available in all Communities, Urban and Rural

Specific Recommendations for USAID, NGOs, and Other Partners

Most of the participants are not very clear about the exact role of USAID and other non-RSS actors, but recommended the following:

- Fully integrate contraceptive services into MCH services to reach women who may be interested in modern contraceptive methods and allow them to access all services in one visit.
- Work with state governments, as well as the MOH, to improve health services and establish more health centers where needed.
- Help develop the CBO sector for child spacing and other health outreach through trainings and small grants to implement community-defined projects.

- NGOs should put more resources into services rather than administrative costs.
- NGOs should operate more actively in the field so communities benefit from their programs.
- Develop and maintain a proper system for monitoring and evaluating all health programs, including child spacing/FP services (recommendation from some service providers).
- One lesson learned by Red Cross is that working through village health committees was ineffective in raising community awareness or creating behavior change. If USAID has not done so already, SHTP-II should learn what happened in these projects before further implementing such a strategy.
- Some respondents, especially in the rural areas, said that USAID should help build more schools and train more teachers. It is clear that education, especially for girls, is directly linked to greater contraceptive usage and better health outcomes (see the Western Equatoria report).

III. RECOMMENDATIONS

Users of this report should be sure to consult the previous section, "Increasing Child Spacing and Use of Contraception: Participants' Recommendations." This section summarizes the researchers' major recommendations.

1. Donors and the government should shift their focus and terminology from "family planning" to "child spacing."

"Family planning" is not an easily understood concept in much (probably most) of South Sudan. Given the persisting cultural norm to marry young and produce as many children as possible, and with polygamy common, the idea of "planning a family" does not fit with any concept of life for the majority of people. Furthermore, it has acquired a negative reputation among the few who have heard of it. Many understand it to mean to permanently terminate childbearing and many associate it with prostitution. "*Family planning is a negative thing in the minds of most people,*" said a senior official in the State Ministry of Health (Upper Nile).

Child spacing, in contrast, is a deeply-rooted and valued cultural norm about which people feel very positive. Traditionally child spacing (*feriku welada ta iyal*) is achieved by two to three years' postpartum sexual abstention by the couple, often facilitated by the man having more than one wife. They know it is important for health of the mother, health of the child and even health of the family. Tradition dictates that the mother breastfeed for two to three years, during which time she should not become pregnant again or serious illness may befall the infant and even entire family. However, many couples are now conflicted because modern life makes three or even two years' sexual abstinence very difficult. This is when some women seek or start to use "modern drugs" (pills, injection or implant) to delay the next pregnancy—often kept secret from their husband. This is not "planning a family," but spacing between children. It is certainly not couples sitting down together to discuss the timing or number children. Many women fear that if their husbands knew they were using contraception he might beat or even divorce them. As concluded in the Western Equatoria report: "The demand for contraceptives (mostly pills, injectables, and condoms) is low. However, some educated urbanites in Western Equatoria seek contraceptives to space their children. None of the interviewees use contraceptives to plan their families."

2. Provide essential upgrading of all basic/primary health care and reproductive health services as a basis for provision of child spacing services.

Upgrading all basic and primary health services would include providing equipment, training for greater provider competency, supplying of essential medicines, beds and labs, and repairing facilities. This is essential for a maternal mortality reduction package. Without this, expanding safe and quality provision of child spacing services will be difficult. Global experience and evidence show that, if women start on a method without adequate support (e.g., pills given them by outreach workers without good information and counseling skills), and these women experience some of the inevitable side effects, they may stop using the method and tell others to avoid it.[36]

Upgrading equipment, especially in the hospitals, must be appropriate to needs and available funding. The team heard reports in Juba that some MOH decision makers had proposed putting MRI machines into the hospitals. First must be provision of basic equipment and qualified personnel. Delivery in a hospital should not be part of the MCH/RH promotion unless the accessible hospital is adequately equipped and staffed to

[36] Nepal is one such country where the focus on "new acceptors," rather than "continuing users," led to backlash over side-effects and significant drop-out (method discontinuation).

handle deliveries. Hospitals also need good management systems. This should come before ultra-sophisticated equipment.

3. Quickly increase the number of midwives, especially community midwives.

The highest priority for reduction of maternal and child mortality, and for RH generally, is to increase the numbers of community midwives (and ensure that they have all basic equipment and medications). This is the consensus of many providers and managers; they also recommended (but less emphatically) more CHWs.[37] The plea (from Upper Nile) is to build a cadre of community midwives (those who get 18 months of training) who can provide the package of basic RH/MCH services, including accurate information on contraception and child spacing. Without this, change and improvement would be extremely slow. Diploma midwives are desirable eventually, but take too long to be trained (three years) to meet present needs. Further, as diploma midwives prefer to work in the cities and urban hospitals, they are not likely to cover needs of more rural areas. [38] **"Awareness" messages to the public should be framed in terms of child spacing for family health and well-being—*not* "family planning."**

"Awareness" (IEC) messages should be framed in the local language by native speakers. Awareness events and messaging should build on and appeal to local values, especially that of child spacing. To be accepted, messages must be in terms that are culturally sensitive and locally understandable, such as below:

> *"Our parents and ancestors were wise in many ways. We all know that our tradition says the mother should breast-feed for three years (or at least two) during which time she should not become pregnant again and, for this reason, the husband abstains from sex with her. This is important for health of the mother, health of the child and even health of the family. Modern science and modern medicine agree that three-year spacing between children is best for everybody in the family—and can help prevent the deaths of women and children. But modern life makes three years abstinence very difficult. Many of us believe two years is an acceptable alternative, but even this is difficult. Fortunately, there are now modern medicines that can let the mother breastfeed for two to three years, without becoming pregnant and without having to abstain from sex. For a woman, the common child-spacing medicines, which are available here, include a pill, an injection, and something called implant. This is a new approach that is good for us in our new country."*

4. Plan awareness events so that they appropriately engage husbands.

Appropriate male involvement is crucial, as men are the decision makers in most aspects of life in South Sudan. The goal should be awareness activities among both men and women to expand their knowledge, as well as to create acceptance among husbands that child spacing—part of South Sudanese tradition—is important for the health of both the mother and child. Child spacing should be promoted as an essential element of MCH or RH services. Religious and local community leaders should be involved in the events. Awareness must be accompanied by availability of supplies as well as improved counseling and monitoring of new contraceptive users, so they do not become confused or disillusioned and stop using the methods. Supportive religious and other community leaders should be involved in these events.

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[37] Providers and managers did not mention pharmacists.

[38] "Refurbish and re-start the midwifery school in Malakal" is the urgent appeal from the County Health Director. But there is acute need for midwives to be serving in Upper Nile (recruited from elsewhere) even before a midwifery school is re-started and producing new midwives. This situation likely prevails in many other states too.

5. Along with health, emphasize the economic difficulties of couples whose children are born too close together, when promoting modern methods of contraception.

Poverty is severe. Many women struggle to access food for their children and families. Children are often sick, but most families cannot afford to pay for treatment for their children or themselves. Some men and some women are beginning to recognize the unfortunate link between having many children and economic difficulties. It is predominantly such individuals who are becoming open to and have even tried contraception.

6. Integrate child spacing promotion and services with other maternal and child health interventions.

Child spacing should be promoted as an essential element of MCH and RH services, building on the established *cultural norms,* which are now reinforced by *modern science*. These include: a two years minimum (three years better) interval between children; exclusive breastfeeding to six months; and pregnancy NOT to occur during breastfeeding. However, child spacing "awareness" counseling is currently not included in pre- and post-natal care (ANC), breastfeeding counseling, post-abortion counseling or childhood immunization. It should be. Currently, funding arrangements result in a vertical "stove-piping" of services and even information. Donors can assist in moving toward a collaborative arrangement in which counseling of new mothers should include: breastfeeding for two years and use of the mini-pill, then other contraceptives for the remainder of the two or three years.

7. Address the needs of young women.

Many young unmarried women, especially those in school, need contraception. An RH advisor in the MOH in Juba summarized: "There is urgent need to re-think the definition of family planning. These young women (single women over 18, who need contraception) should not be turned away. The main cause of death of young women is unsafe abortion." This suggests that USAID and partners consider the approach that USAID defines as "Health Spacing and Timing of Pregnancy" (HTSP). In this approach, healthy times for a pregnancy include: after age 18 and more than 24 months after a live birth (that is, less than approximately three years birth-to-birth). HTSP differs from birth spacing approaches that refer only to spacing between births and provides guidance on the healthiest age for the first pregnancy.[39]

8. Support the MOH in efficiently meeting people's urgent expectations of their new state government.

As noted throughout this report, local people's expectations for what their new government should do to help them are substantial. "*We are at a crossroads*," said one state official. "*We are now coming out from this war which has destroyed all infrastructure, everything. It is the time when our new government must help.*" Collaboration and effective communication channels between the Juba MOH and the state MOHs remain to be developed. Donors can assist this by planning interventions in ways that more directly involve both the MOH in Juba and the state MOHs.

9. Put research and recommendations into action.

State officials and some service providers lament that many assessments have been conducted in their areas during recent years, but with virtually no feedback in terms of improvements of the facilities and services investigated, nor even of report sharing. This is against all principles of development. Research should be a tool to plan: to identify and then close the gaps. If review of research results takes place only in Juba, it is of no use. Most such assessments and visits took

[39] USAID. "Healthy Timing and Spacing of Pregnancy." (Background paper). Office of Population and Reproductive Health: Washington, D.C. 2010. Contact: Maureen Norton (GH/PRH/SDI), mnorton@usaid.gov

place before independence. Expectations are now high that the new government of the new South Sudan will respond to the already thoroughly identified local needs. It will be important for USAID to also share with the SMOHs the four state reports that document findings in each of the four states during this study. These will be of greater relevance and interest at the state level than just this overview report.

10. Focusing on geographically remote and hard-to-reach areas is not practical at this time and not until transportation to villages is improved.

Not only is demand extremely low in geographically remote areas, but delivering information and services to remote areas is a major challenge and would be a drain on the nascent program. A great deal of effort would be required to reach the rural populations in these three states. At present, many of the rural communities have little or no knowledge of contraception/FP and its benefits. The government and donors should build goodwill by improving the most basic health services in rural areas and increasing child survival in this way. Until then, efforts to introduce modern contraception are likely to be met with hostility.

It is recommended that the SMOH take a more active role in closely supervising and following up with facilities and their progress. The SMOH should help CHDs ensure adequate provision of the most basic health services, including the most needed medicines and supplies, before undertaking any intense effort to promote modern methods of child spacing to remote and hard-to-reach populations (nomads, returnees, people living in geographically remote areas). At this time, there is so much misinformation, even in urban areas such as Wau and Malakal, that expensive, time-consuming outreach is not advised (see Appendix E, where maps show the imbalance in population distribution in the states).

Instead, in the near term, programs should use a radial approach to increasing availability and use of modern child-spacing methods, saturating the state capital and peri-urban communities and moving outward as uptake increases and examples of success can be built upon.

(The research teams did not interview nomadic populations or returnees specifically. Returnees are said to be integrating into existing communities so could be reached via whatever community outreach is being done. Any formative research for message development should explore whether returnees require a different approach and set of messages.)

11. Revise and update the MOH's draft family planning policy.

The evidence from this study indicates that a revision is in order of the Government of Southern Sudan's Draft Family Planning Policy (prepared in large part by consultants in November 2009).[40] This document ignores the lessons learned globally during past decades when the best-practice approach to launching contraceptive use in many African countries has been birth spacing and family welfare. "Launching" refers to countries with a CPR of 0 to 10%. In contrast, what is described in this Southern Sudan draft document is a strategy for a country in the family planning expansion stage with a 10 to 20% CPR.

12. Do not seek to reduce violence against women via family planning.

USAID has asked whether it is possible to decrease violence against women (VAW) by promoting family planning. Findings from this study, and the global literature, suggest the answer is "no" for South Sudan. This is often a good idea in countries where contraceptive use has reached a much higher level of acceptance—e.g., CPR above 20%. But in communities that are hostile to FP, as are many in South Sudan, it would be too hard to do successfully, and no

[40] Government of Southern Sudan, Ministry of Health. "Family Planning Policy." Draft, November 2009. Key elements of programs in the "launch" and "expansion" stages are discussed in "Training for the 21st Century: Directions in Family Planning Education and Training." USAID Office of Population, Information and Training Division. 1992.

measurable impact could be achieved. All RH programs should be designed to include anti-VAW activities and messages *where feasible and practical*[41] But reducing violence against women should not be a formal objective of a child spacing/family planning program in South Sudan at this time.

[41] A positive example is the "Clinical Management of Rape," training conducted by ARC for county-level government officials and providers in Upper Nile State, August 2011.

APPENDIX A: SCOPE OF WORK

Global Health Technical Assistance Project
Contract No. GHS-I-00-05-00005-00
Scope of Work

(Revised: 06-20-11)

I. TITLE

Activity: USAID/South Sudan: Family Planning Demand Rapid Assessment
Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

The anticipated period of performance is from on/about **July 2011** until on/about **October 2011**. The in-country work is expected to take place in July–August 2011. *The exact dates are still to be determined and will be dependent on the availability of consultants and level of effort (LOE) calculations.*

III. FUNDING SOURCE

USAID/Sudan (Family Planning funds with GH Tech).

IV. PROBLEM STATEMENT:

The contraceptive prevalence rate (CPR) for South Sudan is estimated at 3.5% and the modern-method CPR is estimated to be less than 1 percent of women of reproductive age. High levels of illiteracy (particularly female illiteracy) and high poverty rates, highly traditional gender roles, presumed pro-natalist attitudes, limited information about family planning methods and benefits, poor access to family planning counseling and delivery services, and low or absent supplies of contraceptive commodities all contribute to the low CPR. Lack of up-to-date data on family planning knowledge, demand, and method preferences hampers the development of effective programmatic responses to improve family planning. The proposed GH Tech Family Planning Demand Qualitative Study will respond to this shortcoming as South Sudan heads into independence in July 2011.

V. PURPOSE:

- To obtain qualitative information that will improve understanding of knowledge, attitudes, and practices about fertility, birth spacing and limiting, and family planning and reproductive health services.
- To support the Government of South Sudan (GOSS) Ministry of Health (MOH), development partners, UN agencies, and health implementing partners in developing evidence-based strategies, policies, and programs to effectively scale up family planning and reproductive health activities and services that respond to the preferences, needs, and priorities of its key target audiences.
- To identify and recommend potential mechanisms to engage local government and community support for family planning and birth spacing.

VI. OBJECTIVES:

Conduct a qualitative participatory rapid assessment that will include:

- Analysis of existing quantitative data and qualitative documentation on family planning and reproductive health in South Sudan.
- Collection and analysis of qualitative data gathered through one-on-one interviews, focus groups, and key informant interviews in the three regions of South Sudan. Key target individuals and groups will include, but are not necessarily limited to, new family planning acceptors, continuing users, spouses and other influential family members, community and religious leaders, health providers, program managers, and government and non-governmental partners.

VII. BACKGROUND:

Family planning falls under the GOSS/MOH Directorate of Primary Health Care and within the Department of Reproductive Health. In 2009 the GOSS drafted a Family Planning Policy with technical assistance from USAID and UNFPA. However, in March 2011, this policy had not yet been officially approved. The Sudan Household Health Survey (SHHS) of 2006 was the main data source used in developing the 2009 draft GOSS Family Planning Policy. Although a 2010 SHHS has been conducted, data from that survey have not yet been officially released by the government (although data release is imminent). Thus, donors and implementers are currently working with limited and potentially outdated quantitative information and virtually no geographically comprehensive, systematically-gathered qualitative data.

USAID has provided family planning commodities, mainly condoms, oral contraceptives, and injectables, through John Snow Inc.'s DELIVER project and, to date, has provided them through the USAID Mission's flagship primary health care project, the Sudan Health Transformation Project II (SHTP-II). SHTP-II includes family planning and reproductive health as one of its seven high-impact essential services to nine subcontracting partners (primarily international NGOs) and potentially 165 facilities. Through SHTP-II, USAID also supports provision of family planning counseling and health education in selected South Sudan counties and has furnished training in USAID family planning principles and policies, such as voluntarism, informed choice and compliance with standards for voluntary family planning service delivery. Currently, 51 of the 165 USAID supported health facilities have been trained in family planning compliance with a goal of 80 fully trained by May 2011.

USAID Sudan also holds a contract with Family Health International for the Sudan HIV/AIDS Program (SHAP), which integrates family planning into HIV/AIDS services. SHAP provides family planning counseling within HIV counseling and testing services and provides referrals to clients seeking family planning methods.

USAID has recently revitalized the Interagency Reproductive Health Technical Working Group, which serves as a technical resource base to the MOH in the development of reproductive health policies and implementation of evidence-based reproductive health programs and activities in South Sudan. In 2011, USAID plans to place a long term Senior Technical Advisor for Family Planning and Reproductive Health within MOH Department of Reproductive Health to enable the government to support its strategic objectives of reducing maternal mortality and morbidity and reducing neonatal and under-five mortality by increasing demand for family planning. It is expected that the findings of this Family Planning Demand Qualitative Study will be of immense value to this Advisor and the MoH Department of Reproductive Health in furthering their family planning strategic, policy, and programmatic implementation goals.

VIII. PROPOSED STUDY METHODOLOGY:

USAID/Juba envisions a "Participatory Rapid Appraisal" or comparable "Participatory Assessment" approach that collects information from target individuals and groups to gather qualitative data regarding knowledge, attitudes, and practices on fertility and family planning. The

study tools will be designed to collect data useful for designing generic behavior change communications and/or behavior change interventions. The study design and implementation must follow U.S. Government Family Planning compliance requirements.

Assessment methodology will include, but are not necessarily limited to, one-on-one interviews, focus group discussions (FGDs), and key informant interviews with stakeholders in three regions of South Sudan: Bahr- El-Ghazal, Upper Nile, and Equatoria. One consultant will cover each region. Consultants should take care to include respondents with diverse characteristics, such as residence, sex, and age, as well new family planning acceptors; continuing users; spouses and other influential family members; community and religious leaders; health providers; program managers; and government and non-governmental partners. USAID may also recommend a higher share of interviewing in those states or counties where USAID projects are currently operating or where USAID might have a future interest.

Prior to travel to South Sudan, the GH Tech consultancy team will engage in telephone calls or meetings and other virtual communications with the USAID/South Sudan FP focal person and the wider USAID health team and the Directorate of the MOH Directorate of Reproductive Health to begin discussions about the study plan. However, the plan will only be finalized after full discussions and approval by the MOH. After full consultations with the Mission, the MOH, and possibly other key stakeholders, the team will:

1. Develop interviewer topic lists or questions.
2. Identify key agencies and informants.
3. Identify geographic areas.
4. Identify interview teams.

To facilitate desk review prior to travel, the GH Tech consultants will be provided with a complete set of documents and materials developed by the MOH, development partners, and implementers working in family planning and reproductive health arena in South Sudan.

Study Design and Instrument Development:

The GH Tech consultant team and USAID/South Sudan will consult with the Ministry of Health (at national, state, and county levels) and other key stakeholders, including (but not necessarily limited to) UNICEF, UNFPA, the Joint Donor Team, DfID, CIDA, the EU, Marie Stopes International, PSI, and SHTP-II.

The team is expected to raise the capacity of the MOH to conduct a rapid assessment that collects qualitative data. The interview teams should also include a member of the County Health Departments. The team should also expect to pre-test the instrument and use methodologically sound and rigorous techniques (including possible use of software) to enter and analyze the data. The team should also expect to present the findings at a stakeholder's meeting.

Even though the study team will develop the topic list or questionnaire in consultation with the MOH and other key stakeholders**, illustrative** topics and questions that might be included in the assessment include:

1. What are the prevailing fertility norms in South Sudan (by region, sex, age, etc.) and why do people hold them? What is an ideal family size?
2. What is the level of demand for FP in South Sudan?
    a. If so, who would be most interested in FP services (e.g. by gender, parity, age group, marital status, education level, urban/rural)?

b. If so, what contraceptive methods are most desired (or would be most appropriate for needs evidenced and the delivery context)

c. Is there a significant unmet need for family planning in South Sudan? If so, is it for spacing or limiting births?

3. Are there barriers to using FP?
   a. If so, what are the most frequently mentioned barriers?
   b. Are these cultural? Or social? Geographic? Cost/perceived cost? Fear of side effects?
   c. Are some of the demographic groups interviewed (obtain breakdown by parity, age, gender, urban/rural, etc.) be more/less likely to use FP services?
4. Given the findings from question 2, what factors might enable or encourage FP uptake?
5. Where do opportunities exist for introducing or expanding FP activities or services?
6. Who is currently providing FP services in South Sudan?
7. What kind of services are they providing?
8. What are the best ways to reach potentially hard-to-reach populations (nomads, returnees, people living in geographically remote areas)?
9. How can communities (particularly community notables) best learn about and encourage appropriate birth spacing and FP?
10. What are the ways that USAID/South Sudan and the MOH can better support family planning and reproductive health services in South Sudan?

Activities and Timeline:

- Review background documents, including relevant surveys, assessments and trip reports on family planning and reproductive health in South Sudan and other relevant countries.
- Develop questionnaire/topic list, list of geographic areas, list of key informants, pretest design, data entry (including software if needed), analysis design, and results presentation and reporting formats.
- Plan the logistics for the pretest, main study, and dissemination workshop (with MSI).
- Provide training as well as management and technical guidance for the fieldwork to the government and other relevant stakeholders.
- Provide technical guidance to the study team in performing the fieldwork in the South Sudanese region of assignment.
- Provide guidance for the data entry (including software if needed) and analysis.
- Provide oversight for the stakeholder presentation.
- Draft preliminary and final reports.

Pre-Assessment Phase:

- Conduct literature review (outside South Sudan).
- Discuss study plan with Mission and key stakeholders (outside South Sudan).
- Conduct a two-day team planning meeting (TPM) upon arrival in-country.
- Conduct in-brief with USAID/South Sudan and the MOH.
- Meet key stakeholders. Inform them and receive feedback about the assessment.
- Develop questionnaire/topic list, list of geographic areas, list of key informants, pretest design, data entry (including software if needed), analysis design, and results presentation and reporting formats.

- Train government and other stakeholder counterparts in the methodology.
- Conduct a pretest and guide the analysis of the pretest results.
- With MSI, make logistical arrangements for the training, study implementation, and stakeholder workshop presentation.

Assessment Phase:

- Pay informational and courtesy visits to relevant government and non-governmental officials and staff in the field areas.
- Conduct the assessment in the selected field sites.
- Review and edit questionnaires/topic lists in the field for validity and consistency (triangulation with other interview team members).

Post-Assessment Phase:

- Enter the data (using software if needed).
- Hold meetings with the team to triangulate the data.
- Conduct an out-brief meeting with USAID/South Sudan and the MOH.

Stakeholders Workshop:

- Provide technical assistance in a one-day workshop to present findings and conclusions for key stakeholders.

Reporting:

- Draft final report.

IX. DELIVERABLES:

Team Planning Meeting (TPM)

The GH Tech assessment team will start their work with a two-day planning meeting prior to the onset of key stakeholder meetings and work with USAID and the MOH. The purpose of the TPM will be to clarify team roles and responsibilities; develop the work plan and methodology; and to create a timeline and action plan for completing the deliverables. In the meeting, the team will specifically:

- Share background, experience, and expectations of each of the team members for the assignment.
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities.
- Agree on the objectives and desired outcomes of the assignment.
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
- Develop the study plan, timeline, and strategy for achieving deliverables.
- Develop and finalize study tools/instruments and topic lists.
- Develop preliminary outline of the team's report and assign drafting responsibilities for the final report.

During the TPM, an in-briefing with USAID/Sudan and the MOH will be held to discuss expectations of the assessment.

Study Plan and Methodology

The team leader will submit the study plan and methodology to USAID/Sudan, MOH, and GH Tech after the TPM. The study plan and methodology will demonstrate how the team will gather qualitative data regarding knowledge, attitudes, and practices on fertility and family planning in South Sudan. It will include the study plan and timeline; study tools and instruments such as questionnaires and topic lists; analysis plans; implementation schedule; and draft report outline. USAID/Sudan will review the proposed study plan/methodology and submit written comments to the Team Leader. The evaluation team will meet with key stakeholders to inform them about the assessment and solicit their feedback on the study plan and methodology. The team will also pre-test the study tools/instruments. The assessment team will revise the study plan and methodology based on discussions key stakeholders and pre-testing results and submit them to USAID/Sudan, the MOH, and GH Tech for review. The work plan and methodology must be finalized and approved by USAID prior to the initiation of the interviews and site visits.

Stakeholder Workshop

The assessment team will present the findings and analysis in a one-day stakeholders' meeting. The summary of initial findings in relationship to key objectives of the study will be shared with USAID, the MOH, and GH Tech prior to the stakeholder workshop.

Draft Assessment Report

The team leader will submit a summary of the main study findings to USAID/South Sudan and GH Tech before departing the country. The team leader will then send the draft report to USAID/South Sudan, the MOH, and GH Tech within one week of departing South Sudan (not including travel days). The draft report will provide an analysis of study findings and answers to the key study questions in relation to the key objectives of the study. This draft report will include the study methodology, findings, and recommendations for review and comment by USAID/South Sudan. The Mission will provide consolidated, written comments to the evaluation team and GH Tech within 10 working days of receiving the draft report.

Final Assessment Report

The team leader will submit the final, unedited report to USAID/South Sudan, the MOH, and GH Tech within 10 working days after the team receives consolidated comments from USAID/South Sudan. GH Tech will provide the edited and formatted final document approximately 30 days after the MOH and USAID/South Sudan provide final approval of the content. USAID/South Sudan and the MOH request both an electronic version of the final report and five hard copies of the report. The report will be released as a public document on the USAID Development Experience Clearinghouse (DEC) (http://dec.usaid.gov) and the GH Tech project web site (www.ghtechproject.com).

X. TEAM COMPOSITION, SKILLS, AND LOE

USAID/South Sudan is calling for a team of three consultants (including a team leader). Each team member will cover one region of the country (Bahr-El-Ghazal, Upper Nile, and Equatoria), and the team leader will coordinate and oversee the qualitative study. The team leader will be responsible for the overall technical direction of the assignment to ensure the quality and appropriateness of the deliverables

Each team member should have the following qualifications and experience:

1. At least a Master's Degree in public health or a related field.
2. Five or more years of experience in a developing country, preferably in Africa. Previous experience in southern Sudan is desirable.

3. Three or more years of experience conducting rapid assessments with qualitative data.
4. Good mentoring and training skills.
5. Good presentation skills and fluency in English.
6. Ability and willingness to travel to remote areas in inclement weather.

In addition to the qualifications listed above, the team leader should have prior experience successfully leading qualitative rapid assessments in developing countries. The team leader should have a technical background in FP, excellent coordination skills, and demonstrated ability to facilitate discussions with high level officials and multiple donors.

Illustrative LOE by Task:

Activity	LOE
Review background materials.	3 days
Begin study design discussions with USAID and key stakeholders.	2 days
Travel to/from South Sudan.	4 days
Conduct Team Planning Meeting.	2 days
Meet with key stakeholders to develop study plan and methodology; develop questionnaire/tools; prepare training materials; finalize study plan, methodology, tools, and logistics.	4 days
Train local counterparts in study tools and methodology and pre-test questionnaire as part of training.	3 days
Conduct study in field sites	13 days
Review and analyze data; develop summary of initial findings; present initial findings to key stakeholders	5 days
Write draft report	9 days
Revise report to address consolidated feedback from USAID (TL=5/TMs=4)	5 days/4 days
Total LOE—Team Leader (TL)	50 days
Total LOE - Team Members (TMs)	49 days

USAID/Sudan authorizes a six-day work week when the team is working in-country.

XI. LOGISTICS

MSI will provide support in-country to arrange appointments and to handle logistics of travel and accommodations. MSI will cover in-country logistical costs such as per diem for development partners participating in the survey; in-country transportation (for international consultants and development partners); and training and stakeholder workshops.

GH Tech will provide for international transportation to and from Sudan and cover costs of local lodging and per diem, as appropriate for the consultant team.

XII. RELATIONSHIPS AND RESPONSIBILITIES

Prior to In-country Work:

- Consultant Conflict of Interest. To avoid conflicts of interest (COI) or the appearance of COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding any potential COI.
- Background Documents: Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.
- Key Informant and Site Visit Preparations: Provide a list of key informants, list of health facilities and suppliers, and suggested length of field visits for use in planning for in-country travel and accurate estimation of country travel line items costs (i.e., number of in-country travel days required to reach each destination, and number of days allocated for interviews at each site).
- Lodging and Travel: Provide information as early as possible on allowable lodging and per diem rates for stakeholders that will travel/participate in activities with the evaluation team. Also, provide guidance on recommended secure hotels, and identify a person in the Mission to assist with logistics.

During In-country Work:

USAID/Sudan will undertake the following while the team is in country:

- Mission Point of Contact: Ensure constant availability of the Mission Point of Contact person(s) to provide technical leadership and direction for the consultant team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and workshops (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements and Field Visits. While consultants typically will arrange meetings for contacts outside the Mission, support the consultants in coordinating meetings with stakeholders and organizing site visits.
- Formal and Official Meetings. Arrange key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings).
- Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local development partners relevant to the assignment.
- Facilitate Contacts with Partners. Introduce the team to project partners, local government officials, and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

Following In-country Work:

USAID/South Sudan and the MOH will undertake the following, once the in-country work is completed:

Timely Reviews: Provide timely review and approval of the survey methodology/work plan and draft/final draft reports.

XIII. POINT OF CONTACT AT THE MISSION

Clifford Lubitz

Deputy Health Officer
USAID I Sudan
Juba, South Sudan
VOIP: 1 202.216.6279 Ext. 105 (home), 240 (office)
Zain Cell: +249 (0) 900920310
clubitz@usaid.gov

XIV. COST ESTIMATE

TBD

APPENDIX B: MAIN PERSONS CONTACTED

JUBA

USAID/Juba

Mr. Cliff Lubitz, Chief, Office of Health, USAID/Juba

Ms. Pamela Teichman, Senior Health Advisor, USAID/Washington—on assignment to USAID/Juba

Ms. Margaret D'Adamo, IT and Knowledge Management Advisor, Office of Population & Reproductive Health, USAID/Washington—on assignment to USAID/Juba

Dr. Martin Swaka, USAID/Juba, Office of Health (previously with SHTP), USAID/Juba

Dr. Lorie Broomhall, Senior M&E Technical Advisor, USAID/Washington—on assignment to USAID/Juba

Ministry of Health, Juba

Dr. Samson Paul Baba, Director General for Planning & Coordination

Dr. Richard Lino Loro Laku, Director of Monitoring and Evaluation

Dr. Alexander Dimitti, Reproductive Health Advisor

Juba Teaching Hospital

Dr. Mergani Abdalla Mohamed, Consultant Obstetrician and Gynecologist

Other Partner Organizations

United Nations Population Fund (UNFPA)

Dr. Ramiz Alakbarov, MD, MA, PhD, Head of Office

Canadian International Development Agency (CIDA)

Ms. Emily Alexander

International Rescue Committee

Ms. Susan Purdin, Country Director

Sudan Health Transformation Project (SHTP-II)

Mr. John Rumunu, Director SHTP-II

Management Sciences for Health

Mr. Fred Hartman, Project Director/HQ

Marie Stopes International

Mr. Simon Harris, Interim Country Director

Population Services International

Ms. Julie Steiger and Mr. Jason Waldon

Adventist Development and Relief Agency (ADRA)

Mr. Christopher Otti

ARC International, South Sudan

Gina Paulette, Interim Country Director

Gurei Primary Health Care Center

Benjamin Amoko Jme, Manager in Charge, and Loice Lamadi, Community Midwife

UPPER NILE STATE

Government

State Ministry of Health, Upper Nile State

Mr. Stephen Lor Nyak, State Minister of Health

Dr. Lul Deng, Director General

Dr. James Deng, Director of Primary Health Care

County Health Department

Mr. Andrew Kudrit, Director

Malakal Teaching Hospital, RSS/MOH

Dr. Gabriel Daniel, Director General

Non-Governmental Organizations

American Refugee Committee (ARC)

Joseph Duop, Reproductive Health Advisor, Upper Nile State

International Medical Corps (IMC), USAID sub-contractor under the SHTP-II

Mr. John Suraj, Project Director

Mr. William Apar, Site Manager

Mr. Philip Nyikang Opwol

WESTERN BAHR EL GHAZAL

Government

State Ministry of Health, Western Bahr el Ghazal

Dr. Isaac Cleto H. Rial, Minister of Health

Dr. Achanglo Bambo Nela, Director General

Rayo Dimo, Health Officer

Wau Teaching Hospital, RSS/MOH

Dr. James Okello Morgan, Director General

Majuk Malek, Medical Director

Lina Ferdinand Musa, Principal Midwife, Antenatal Care and School of Midwifery ANC Clinic

Wau County Health Department

Dr. Abdalla Karmana, County Medical Officer

Catherine Peter Battal, Public Health Officer

Regina Pasquali Musa, Supervisor, Acting RH Officer

Raja County Coordination Office, Wau

Momayigi Alamin, Administrator

Non-Governmental Organizations

John Snow, Inc. (JSI) / Sudan Health Transformation Project (SHTP-II)

Dr. Morris Timothy Ama, Project Director, JSI, Wau

Ms. Angelina Rene, Reproductive Health and HIV/AIDS Manager

South Sudan Red Cross, Wau

Joseph Lukak Charles, Project Coordinator

Lokoloko PHCC

Rabha Elias, Health Visitor

Bazia Jedid PHCC: Umjima Sende, Health Visitor

Sisters Association for Women Building Capacity

Serafina Sabina, Foreign Relations Secretary

UNICEF

Ms. Paula Nuer, Health and Nutrition Specialist, Wau Zone

WESTERN EQUATORIA

Non-Governmental Organizations

Mundri Relief and Development (MRD)

Mr. Bojo Samuel Scopas, Area Coordinator, Family Health International/Western Equatoria State

APPENDIX C: REFERENCES

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--- "Healthy Timing and Spacing of Pregnancy" (Background paper). 2010. Office of Population and Reproductive Health: Washington D.C.

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APPENDIX D: PHARMACY VISITS IN MALAKAL, CAPITOL OF UPPER NILE STATE

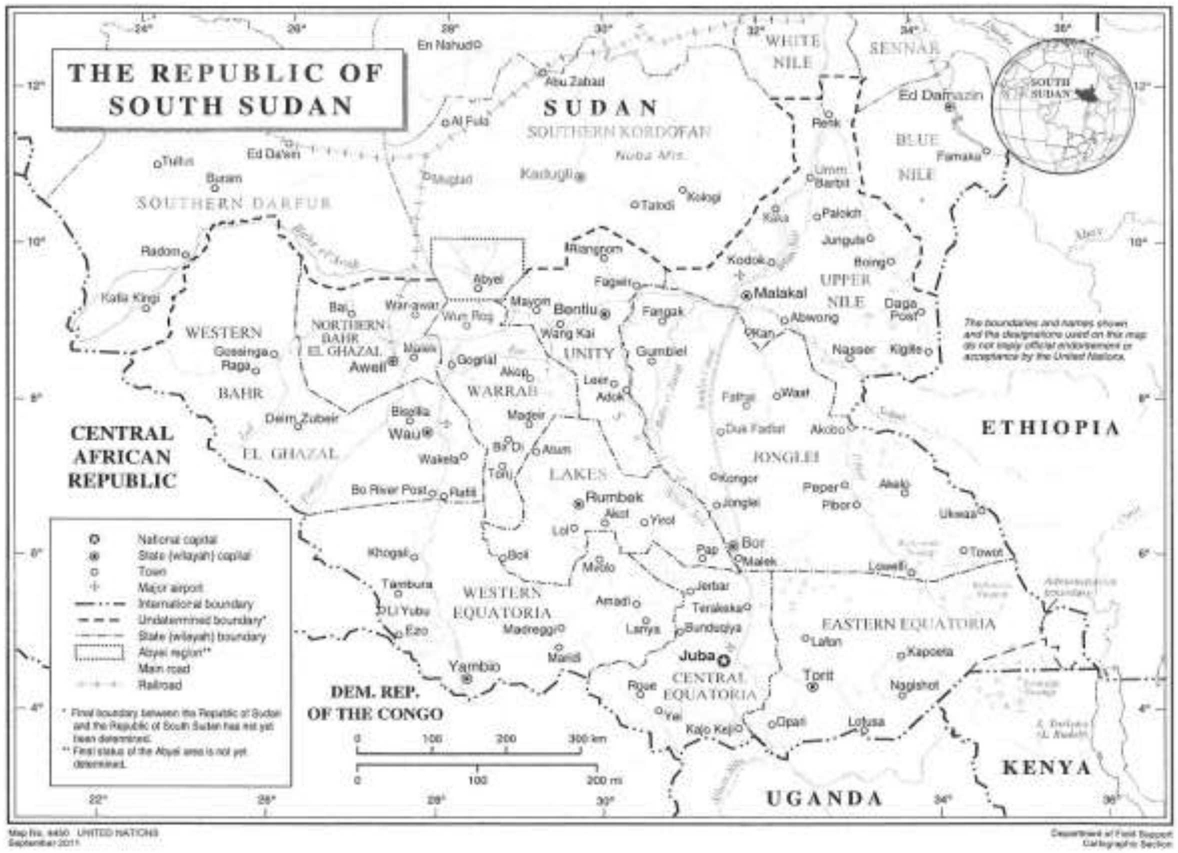
The research team made short visits to six pharmacies in the center of Malakal to ask about availability of contraceptives (on 22 August 2011). As the visits were short, details below are illustrative.

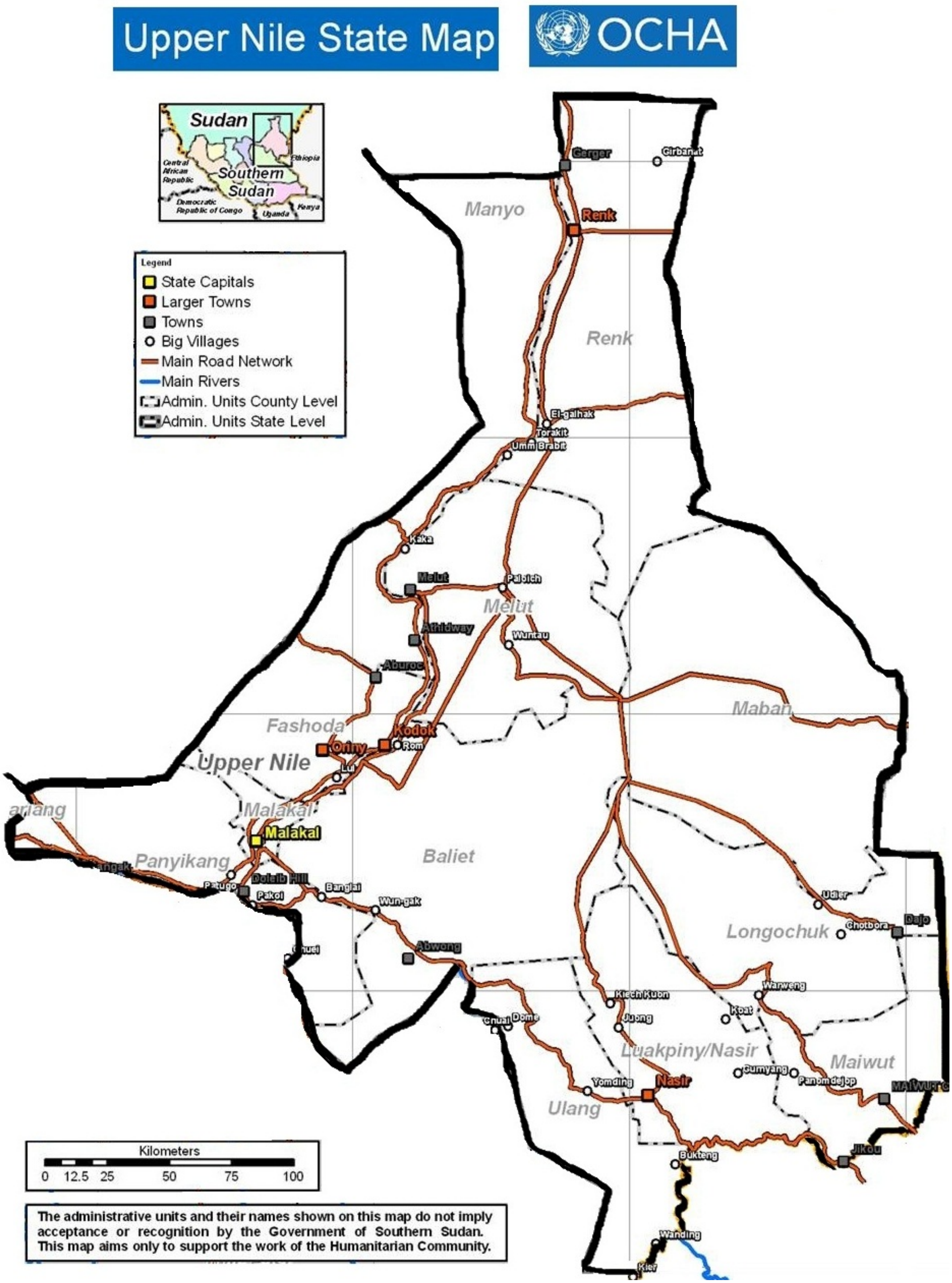
1. Pharmacy across from Malakal Teaching Hospital. This appears to be the main pharmacy servicing MTH patients.
   - **Pills:** two kinds.
     - One is "Familia" brand COC, from Zafa in Karachi.
     - The other was [long name something like Phygyntemol]; 11 tablets in the box + some brown; labeled outside and in the insert "Not for Oral Contraceptive Use."
   - **Injectible:** yes.
   - **Condoms:** Had previously, but "finished."
2. Malaka al-Kabiya. Pharmacist/sales person came from Khartoum.
   - **Pills:** Same "Familia" brand COC, from Zafa in Karachi. 4 SSP/pkg (for 1 month)
   - **Condoms:** Yes, 1 SSP for the strip of three.
   - **Injection:** Finished.
   - **Counseling?** Yes, advises a bit, based on what he learned in Khartoum. People come from MTH.
3. Atar Modern Pharmacy.
   - **Condoms** only. Same silver metal-packed strips of three on shelf in Wau Shilluk. (Made in Korea?) Strip of three costs 1 SSP. Little demand; no regular customers. Nothing for women.
4. Elmoda Community Pharmacy.
   - **Nothing.** Has no contraceptive products at this time. People come requesting. He'd be happy to sell if supply came to him.
   - **Condoms:** Finished. Previously had two kinds:
     - The silver strips of three.
     - A box with a picture on it of person(s). People liked this one best. Someone sent it to him. Would like more of these.
5. Saha Afia.
   - **Nothing.** Previously had condoms, pills and injection, but all three finished. Customers come requesting; he tells them to look elsewhere (no specific).
6. El Abnos Modern Pharmacy.
   - **Nothing.** Has no contraceptive products; never did. People come requesting. He'd be happy to sell if supply came to him.

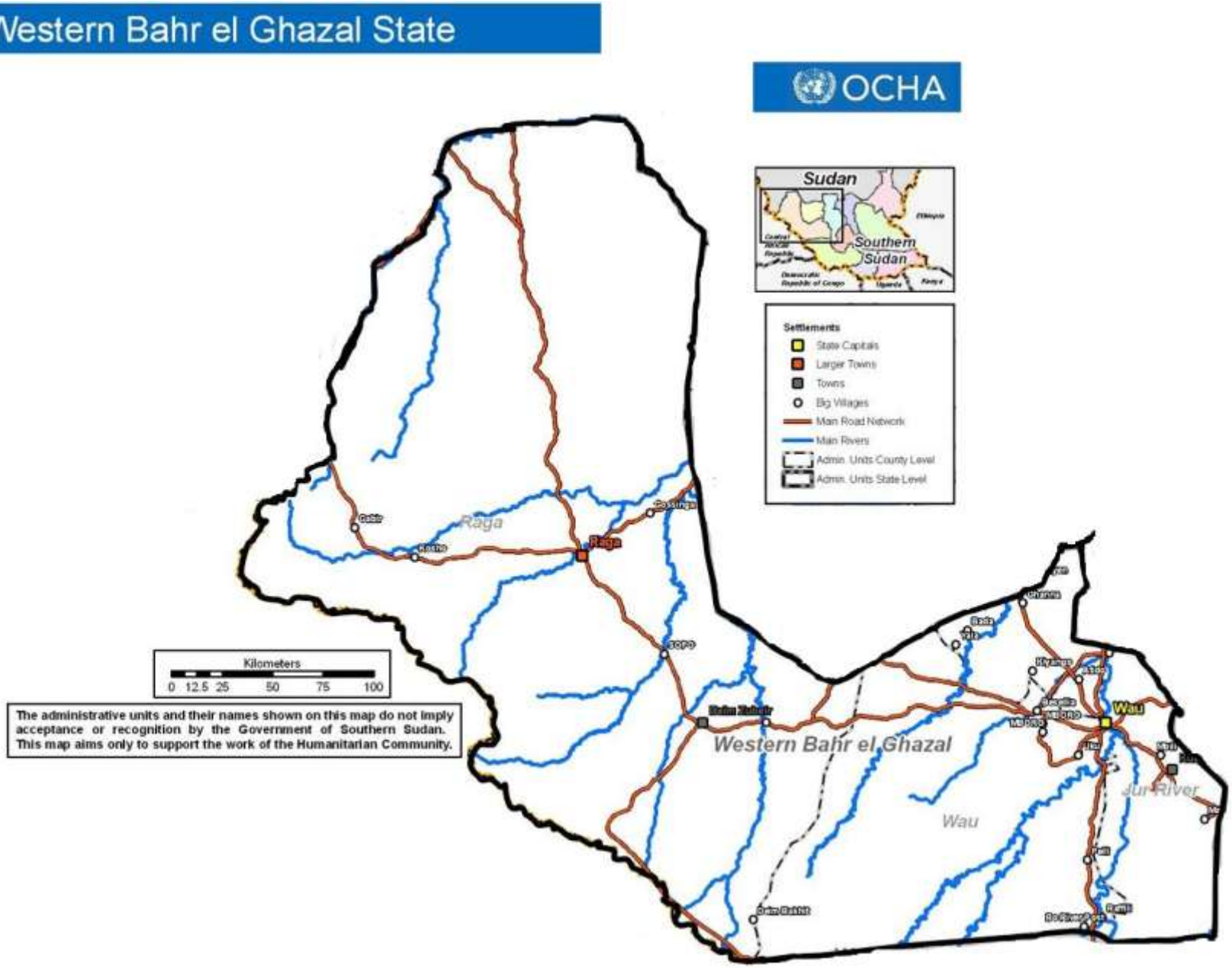
Powdered milk. Cans of powdered milk dominate the display at pharmacy #1. Brands: Bebelac (from UAE), Liptomama (Swiss, vanilla flavored), Liptomil (Swiss). Cost 30 SSP. These cans are displayed and sold in all the pharmacies visited. One pharmacist said there is another kind with sugar in it; this is more popular.

Emergency contraception. Never mentioned in UNS. But a pharmacy in Juba carries and showed us Postinor, which he said many women use**.** He said it is valid for three days [72 hours].

APPENDIX E: MAPS—SOUTH SUDAN, UPPER NILE STATE AND WESTERN BAHR EL GHAZAL STATE




Upper Nile State Map
OCHA
Sudan
Central African Republic
Southern Sudan
Ethiopia
Democratic Republic of Congo
Uganda
Kenya
Legend
State Capitals
Larger Towns
Towns
Big Villages
Main Road Network
Main Rivers
Admin. Units County Level
Admin. Units State Level
Manyo
Gerger
Girbanat
Renk
Renk
El-galhak
Torakit
Umm Brabit
Kaka
Melut
Paloich
Melut
Wuntau
Athidway
Aburoc
Maban
Fashoda
Kodok
Oriny
Rom
Upper Nile
Lul
Malakal
Malakal
Panyikang
Patugo
Doleib Hill
Pakoi
Banglai
Wun-gak
Baliet
Abwong
Udier
Chotbora
Dajo
Longochuk
Warweng
Kiech Kuon
Koat
Juong
Cnual
Dome
Luakpiny/Nasir
Maiwut
Gumyang
Panomdejop
Yomding
Nasir
Ulang
Jikou
Bukteng
Wanding
Kier
Kilometers
0 12.5 25 50 75 100
The administrative units and their names shown on this map do not imply acceptance or recognition by the Government of Southern Sudan. This map aims only to support the work of the Humanitarian Community.


Western Bahr el Ghazal State
OCHA
Sudan
Southern Sudan
Settlements
State Capitals
Larger Towns
Towns
Big Villages
Main Road Network
Main Rivers
Admin. Units County Level
Admin. Units State Level
Raga
Wau
Western Bahr el Ghazal
Jur River
Kilometers
0 12.5 25 50 75 100
The administrative units and their names shown on this map do not imply acceptance or recognition by the Government of Southern Sudan. This map aims only to support the work of the Humanitarian Community.

For more information, please visit
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