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ABSTRACT

MOMENTUM Integrated Health Resilience, with funding through USAID/South Sudan, conducted an assessment in 2021 of social norms related to voluntary family planning and reproductive health (FP/RH) in South Sudan, as well as exploring issues of menstrual hygiene and management (MHM), gender-based violence (GBV), and health-seeking behavior. The assessment goal was to provide evidence to inform the development of USAID/South Sudan's social and behavior change (SBC) efforts related to increasing use of and improving FP/RH, prevention and awareness of GBV, and strengthening health-seeking behavior. Information was also gathered on influencers and gatekeepers of social norms in South Sudan. Study findings, which provide rich insight into how social norms influence and hinder women's agency to use modern contraception, will inform MOMENTUM Integrated Health Resilience FP/RH programming. For example, child spacing was found to be important, but social norms require a husband's consent for modern contraception by the wife. Breaching this consent puts both the woman and her FP provider at risk of GBV.

Assessment recommendations are provided, and include building on positive norms as an asset to promote FP; supporting male engagement strategies; engaging influencers as change agents in social norms transformation; and including health providers as partners in SBC and social norms transformation.

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ABBREVIATIONS AND ACRONYMS

CHW	Community health worker
FP	Voluntary family planning
GBV	Gender-based violence
GII	Gender Inequality Index
HDI	Human Development Index
IDI	In-depth interview
IDP	Internally displaced person
IPV	Intimate partner violence
IRB	Institutional review board
KII	Key informant interview
LARC	Long-acting and reversible contraceptive
mCPR	Modern contraceptive prevalence rate
MHM	Menstrual hygiene and management
MIHR	MOMENTUM Integrated Health Resilience
MNCH	Maternal, newborn, and child health
PI	Principal investigator
PPE	Personal protective equipment
RH	Reproductive health
SBC	Social and behavior change
SNET	Social Norms Exploration Tool
SRH	Sexual and reproductive health
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION AND PURPOSE

MOMENTUM Integrated Health Resilience (MIHR), using funding provided by USAID/South Sudan, conducted an assessment of social norms in 2021 related to voluntary family planning and reproductive health (FP/RH) in South Sudan. The assessment also explored issues of menstrual hygiene and management (MHM), gender-based violence (GBV), and health-seeking behavior.

The assessment goal was to provide evidence to inform the development of USAID/South Sudan's social and behavior change (SBC) efforts related to increasing the use of and improving FP/RH, prevention and awareness of GBV, and strengthening health-seeking behavior. To further enhance these efforts, the assessment also collected information on influencers and gatekeepers of social norms in South Sudan. Overall, the study findings provide rich insight into the contexts of five sites where data were collected, and will inform MIHR FP/RH programming going forward.

METHODS

This was a cross-sectional, descriptive assessment that utilized qualitative methods of inquiry to promote an in-depth understanding of social norms in South Sudan and how women and men think about FP/RH and GBV, and to better understand how decisions are made about the use of FP and related health-seeking behaviors. Data collection included stakeholder key informant interviews (KIIs) and in-depth interviews (IDIs) with the study population. The assessment was conducted in five South Sudanese counties that were identified in collaboration with USAID/South Sudan: Budi, Wau, Bor, Leer, and Yambio.

FINDINGS

Some sections of the community are conscious or aware of the benefits of contraceptive use, and hold supportive behavioral expectations on child spacing embedded in community values and aspirations on child well-being. However, this has barely translated into decisions on modern contraceptive use. This can mainly be explained by the restrictive social norms on childbearing, decision-making, and modern contraceptives that constrain women's autonomy and decision-making power on their reproductive health choices.

Some women, adolescent girls, and FP providers exercise agency through negotiations, resistance, and subversive practices, mainly seeking services secretly. However, these forms of agency have not achieved community-wide change on modern contraceptive use. In some instances, these have instead reinforced women's limited FP autonomy and decision-making. Some of these practices have also made women and girls susceptible to physical and psychological GBV.

Women and young people's intention to use modern contraceptives is constrained by social norms that place the decision-making responsibility with the man and his family. The inclusion of the family engenders RH decisions as aspects of collectivism. Given that FP providers are part of the social

network of the community and bounded by the restrictive social norms, they are cautious in their attempt or decisions to provide FP services to women and girls.

Social and gender norms on menstruation define appropriate behavior for girls in their menses, including dietary restrictions and social exclusion from certain social spaces and activities. The norms also define the identity of girls that have started menstruating—as mature, ready for marriage, and adults.

There are several sources of materials for MHM, ranging from relatively more domestic-oriented sources, such as at home, to out-of-home sources, such as riversides or streams. Mothers and peers are the primary source of information on management of menses. Elders, health care providers, and female teachers support mothers in their role.

There is a shared expectation that sex before marriage is prohibited. Arranged marriages are common and an acceptable practice in the community—parents take the lead in negotiations for marriage of their sons and daughters. There are socioeconomic connotations that are associated with marriages—daughters are perceived as a source of such wealth as cows and money.

Gender-based violence in the RH context manifests in the form of reproductive coercion, controlling behaviors, physical violence, forced/early marriages, and psychological violence. Notably, given types of GBV, such as physical and psychological violence, constitute part of the social sanctions prescribed by social norms that hold in place limited autonomy and decision-making of women and girls on RH. These negative social sanctions also extend to FP providers, especially when they provide FP services to women without the consent of their male spouses. Several providers cited instances where they had been physically assaulted, verbally abused, or threatened for providing FP services to women without consent of the male spouse.

Positive or alternative norms, beliefs, attitudes, and practices on modern contraceptive use, MHM, sexual debut, health-seeking behavior, and GBV are beginning to emerge in some sections of communities, especially in the urban areas. These challenge the existing, restrictive, social and gender norms and can serve as building blocks for planned SBC activities.

A range of key influencers of decisions to use modern contraceptives, sexual debut, health-seeking behavior (in relation to FP), and MHM were identified. They are in a position to execute different functions critical to social norm change. The key influencers reinforce in a significant way the dominant attitudes, social norms, and practices common in their communities.

SELECTED RECOMMENDATIONS

- a) Increase women's and girls' agency to initiate conversations with FP providers, in order to promote more meaningful interactions between the providers and women and girls in need of FP.
- b) Build capacity of service providers in providing adolescent-friendly sexual and reproductive health (SRH) services, particularly contraception services, and in establishing adolescent- and youth-friendly corners or spaces to increase discussion and access to SRH information and FP services.

- c) Given the GBV risks associated with women and girls seeking FP services in secrecy, combine programming for promoting uptake of FP with interventions geared toward prevention and response to GBV. Integrated programming for FP promotion and GBV prevention should therefore become a key priority in both SBC and provision of services.
- d) Build on positive norms, especially on child spacing and the values related to healthy children and child welfare, as assets for promoting FP. In doing so, it is important to reflect on the implications of these practices to the well-being and rights of women, to avoid any harmful, unintended outcomes, to adhere to the “do-no-harm” principles, and to promote gender justice.
- e) Provide key influencers with comprehensive information and relevant tools to engage target audiences to foster normative change. Also, key influencers should be engaged as change agents in SBC work and social norms transformation.
- f) Include health providers as partners in SBC and social norms transformation through capacity building and involvement in co-creation workshops for SBC interventions.
- g) Given the male domination in RH decision-making, emphasize innovative male engagement strategies that can harness men and boys as partners in promoting the use of SRH services, including modern contraceptives.
- h) SBC activities should unpack respected community values and gender norms, such as child well-being, maternal health, the importance of healthy children, and healthy fertility across targeted audiences, and allow for co-creation of feasible solutions within households and communities.
- i) Ensure audience segmentation within MHR activity areas. This will facilitate tailored programs and messages during project implementation (e.g., county/payam-level co-creation of SBC activities) in collaboration with Breakthrough ACTION and other key implementing partners.
- j) Incorporate findings into collaborations with Breakthrough ACTION’s innovation teams to integrate SBC messages into information sessions for mothers at health facilities and in community outreach. Identify influential women leaders to organize mother’s groups (including mothers-in-law when appropriate) to facilitate a series of dialogues prioritized by the mothers. These can include, for example, MHM, sexual debut and marriage, and FP care seeking.

INTRODUCTION

MOMENTUM Integrated Health Resilience (MIHR), under funding through the South Sudan Mission of the U.S. Agency for International Development (USAID), conducted an assessment of social norms related to voluntary family planning and reproductive health (FP/RH) in South Sudan, that also looked at issues of menstrual hygiene and management (MHM), gender-based violence (GBV), and health-seeking behavior. This South Sudan Social Norms Assessment report provides information on the attitudes, beliefs, and social norms that drive behaviors and practices that affect FP/RH and GBV. The information will be used to plan effective social and behavior change (SBC) activities and messages aimed at improving access to and use of FP for adolescents and adults in South Sudan, and related health-seeking practices, including MHM and GBV.

BACKGROUND AND RATIONALE

This assessment focused on understanding the role of social norms in driving behaviors and practices related to FP/RH use among men and women in South Sudan. Questions were also included on MHM, GBV, and health-seeking behavior. This was in response to the growing evidence base on the importance of correctly identifying social norms, as well as how to shift norms and measure normative change in SBC programming (Learning Collaborative 2020).

Social norms are the implicit and often unspoken “rules” that predict behaviors or practices within a specific group. Unlike attitudes and beliefs, which are individually held—and are important for this assessment—social norms are the mutual expectations about behaviors that are shared within social groups. Social norms are held in place by “reference groups,” defined as “those people whose expectations matter to a given individual in the situation” (Mackie et al. 2015, p.11). Social norms include norms about “what I think others typically do” (descriptive norms) and norms about “what I think others expect me to do” (injunctive norms). Norms are held in place because of the social rewards of doing so, and because of the anticipated negative sanctions of defying them (Ibid 2015).

Gaining insights into social norms and their key drivers is important for designing SBC programs and activities that are locally appropriate and culturally sensitive to the diverse South Sudanese population, as well as understanding what behaviors can be most effectively targeted. Influencing social norms, in addition to individual attitudes and behavior, supports creating social change at a systemic level and provides the potential to achieve behavior change at scale (Ibid 2015).

According to 2020 estimates, 63 percent of South Sudan’s population is under the age of 25; 42 percent is under the age of 15 (Central Intelligence Agency 2020). Two in five girls in South Sudan are married before the age of 18, contributing to a high rate of teenage pregnancy (300/1,000 girls aged 15-19) (Ministry of Health South Sudan & National Bureau of Statistics 2010). South Sudan’s maternal mortality rates are the highest in the world, with 1,150 deaths per 100,000 births in 2017 (World Bank 2019).

A National Household Survey was conducted in South Sudan in 2020 (Devkota et al. 2021) that showed the contraceptive prevalence rate dropping from 6.5 percent in 2011 to 5 percent in 2015, then down to 4.3 percent in 2020 (Figure 1). Men reported a higher use of FP method (any or modern) than

women (Table 1). South Sudan Core Indicators¹ show the unmet need for FP among married women is 30.6 percent. Yet, in comparison, self-reported unmet need on the National Household Survey was low, with women reporting a higher unmet need than men (women 2.6 percent; men 1.7 percent).

Figure 1. Trend for Women 15–49 Years Using or Whose Partner Is Using a Modern Family Planning Method



Source: National Household Survey conducted in South Sudan in 2020 (Devkota et al. 2021).

Table 1. Family Planning Use, Unmet Need, and Child Spacing

Family Planning Use	
Women 15–49 years who are currently using (or whose partner is using) any FP method	5.9%
Women 15–49 years who are currently using (or whose partner is using) a modern contraceptive	4.3%
Men 15–49 years who are currently using (or whose partner is using) any FP method	9.5%
Men 15–49 years who are currently using (or whose partner is using) a modern contraceptive	6.0%
Unmet Need	
Women 15–49 years who have unmet need for FP	2.6%
Men 15–49 years who have unmet need for FP	1.7%
Child Spacing ²	
Children 0–11 months who were born at least 36 months after a preceding birth	9.8%
Proportion of mothers of children 0–11 months who are currently using a modern contraceptive	3.0%

Source: National Household Survey conducted in South Sudan in 2020 (Devkota et al. 2021).

¹ South Sudan Core Indicators, Track 20, 2019. http://www.track20.org/South_Sudan.

² “The South Sudan National Household Survey” (2020) report states that *children 0–11 months who were born at least 36 months after a preceding birth* [birth spacing], “Nationally, 9.8% of these mothers had an appropriate spacing of children. State by state birth spacing ranged from 16.4% in WBG to 3.1% in Lakes state.” Data by state are: Abyei AA (18.8%); CES (8.2%); EES (14.3%); GPAA (13.9%); Jonglei (9.3%); Lakes (8%); NBG (5%); Ruweng AA (3.5%); Unity (3.1%); Upper Nile (8.2%); Warrap (15.2%); WBG (16.4%); WES (9.2%).

A few small-scale studies have been conducted in South Sudan to assess social and cultural norms that support large families and discourage use of modern contraception. These have identified increased social status for both men and women who have large families (Palmer and Storeng 2016); a strongly patriarchal society that limits women’s agency and decision-making around contraception (Kane et al. 2016; Tancioco et al. 2016); women’s sense of a “national obligation” to replace men lost through war and conflict (Elmusharaf et al. 2017); men’s strong resentment of women’s use of contraception as a threat to “culture and peoplehood” (Mkandawire et al. 2019); and normative associations between the use of contraception and sex outside of marriage or sex work (Ibid 2019). Many of these and similar factors are cited as negative influences for potential users and providers of FP. The extent to which these norms are specific to the sites where studies were conducted, or are common across South Sudan, is unknown, since all studies were conducted in single areas. This assessment provides comparative data across the different data collection sites in South Sudan. Evidence from sub-Saharan Africa shows that modern contraceptive use is lower among polygamous marriages (Baschieri et al. 2013) as co-wives compete to produce children (Jammeh et al. 2014). The polygamy marital structure is common to South Sudan, and is often associated with having a stronger sense of social security within the family, clan, and community. Polygamy is accepted for men but not for women (Madut 2020).

To support USAID/South Sudan’s intention to integrating GBV throughout its portfolio of programming, this study also sought to understand the role of intimate partner violence (IPV) as a barrier to women’s use of FP (Gardsbane & Atem 2019).

Global studies have shown that women who experience IPV are more likely to have male partners who refuse the use of contraception, and they often have little choice about sexual activity (Maxwell et al. 2015). Reproductive and sexual coercion—one form of IPV—affects women’s autonomy around FP and is documented across the globe as a factor for unplanned pregnancies, higher rates of abortion, and higher birth rates (Garcia-Moreno et al. 2005; Silverman & Raj 2014). Evidence does show that non-health structures (e.g., education) can be linked to increased use of modern methods among women and girls (Slaymaker et al. 2020). However, according to some researchers, the specific behaviors that affect girls’ and women’s control over their reproductive health and the social norms relating to connections between IPV and FP are under-studied (Silverman & Raj 2014; McLarnon-Silk et al. 2017). Studies have shown that social norms that underlie harmful practices such as early/child marriage in South Sudan have negatively affected girls’ education and maternal health—girls often have to drop out of school to get married and get pregnant before they are physiologically, emotionally, and socially ready (Ali 2011). This points to intersections between social norms that place less value on girls’ education and GBV, particularly through harmful practices such as early and child marriage.

Table 2. South Sudan: GBV Not Justified

GBV Indicator	Men	Women
All forms of GBV are rejected	45%	41%
Child marriage is not justified	58%	52%
Forced pregnancy or sterilization is rejected	80%	76%

Source: National Household Survey conducted in South Sudan in 2020 (Devkota et al. 2021).

GBV, including IPV, is widespread in South Sudan. It affects women and girls across their life courses, including their ability to make informed and voluntary choices about family planning (Global Women’s Institute & International Rescue Committee 2017). The International Rescue Committee (2017) conducted a study in three South Sudan states that reported 65 percent of women experienced GBV during their lifetime. National Household Survey respondents were asked about their perception of GBV practices. Although there was variation across the states, women were a bit more likely to tolerate and justify violence against women, compared with men. Overall, less than half of respondents rejected all forms of GBV (Table 2). Child marriage appears to be the most acceptable form of GBV: forced pregnancy or sterilization had the highest level of rejection.

Populations within South Sudan are deeply affected from decades of conflict, such as widespread displacement, poverty, and dependence on humanitarian assistance, as well as with trauma from violence, all with consequences for women’s reproductive health (Palmer et al. 2016). In addition, the protracted conflict in South Sudan has wreaked havoc on the country’s basic infrastructure and human capital. Reflecting on the lack of basic health, education, and other services, in 2018, South Sudan was ranked 186 out of 189 countries on the Human Development Index (HDI).³ The “quality of human development” for South Sudan is in the bottom third for all three areas ranked, including quality of health (only one of three indicators even had data); quality of education (two of six indicators had data); and quality of standard of living (all four indicators had data) (United Nations Development Programme [UNDP] 2018). South Sudan does not have sufficient data to be rated on the Gender Inequality Index (GII), a global index that reflects gender-related disadvantages in reproductive health, empowerment, and the labor market (United Nations Development Programme 2020).

Also important to the context of any study in South Sudan, the February 2020 USAID South Sudan Crisis fact sheet reported that an estimated 7.5 million people in the country needed humanitarian assistance as of November 2019 (USAID/South Sudan 2019), with an estimated 5.5 million (47 percent of the population) potentially facing “crisis” or “emergency” levels of food insecurity⁴ in the first quarter of 2020 (Ibid 2019). As of January 2020, there were 1.7 million internally displaced persons (IDPs) in South Sudan (United Nations Office for the Coordination of Humanitarian Affairs 2019).

³ HDI is used to assess progress across three human development dimensions: “a long and healthy life, access to knowledge, and a decent standard of living.” Data used are based on the UN Population Council, UNESCO, and the World Bank. Source: Human Development Indices and Indicators: 2018 Statistical Update: Briefing note for countries on the Statistical Update: South Sudan, UNDP, 2018.

⁴ The Integrated Food Security Phase Classification (IPC) system describes the severity of food insecurity and ranges from 1 (minimal), 2 (stressed), 3 (crisis), 4 (emergency), to 5 (famine).

Despite these barriers, opportunities exist for strengthening the promotion and utilization of FP/RH services. These include the supportive bill of rights that protects the rights of women, men, and children under the Transitional Constitution of the Republic of South Sudan (2011), and the South Sudan National Health Policy (2016–2026) that lays a strong foundation for programming in the health sector. Similarly, the National Family Planning Policy (2013) and the South Sudan Reproductive Health Policy (2019–2029) also provide a national framework access to FP/RH services.⁵ The National Family Planning Policy (2013) also states that individuals of reproductive age (15+) are allowed access to FP/RH services. Other supportive frameworks include the South Sudan Health Sector Development Plan (2012–2016) and the National Reproductive Health Strategic Plan (2013–2016). The government of South Sudan and others have also made commitment to the FP 2020 goals of reducing maternal mortality by 10 percent, and increasing the modern contraceptive prevalence rate (mCPR) among married women to 10 percent. Although these policies and planning frameworks provide opportunities for improving sexual and reproductive health and rights (SRHR), their effective implementation is relatively low, partly due to institutional and resource constraints, as well as the prevailing social norms influencing SRHR (Japan International Cooperation Agency 2017).

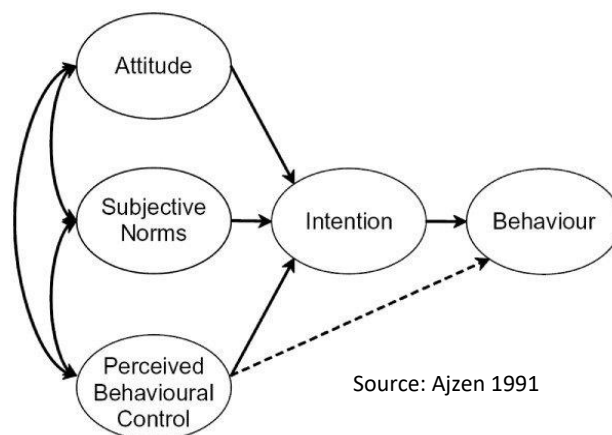
THEORY AND CONCEPTUAL MODEL

This assessment employed the Theory of Planned Behavior (Figure 2) for its orienting framework. The theory explicitly links beliefs and behavior, and argues that intention toward behavior (such as FP use), subjective norms, and perceived behavioral control, together shape an individual's behavioral intentions and actions (Ajzen 1991). For instance, in their qualitative study of the Fertit community in the state of Western Bahr, el Ghazal, Kane et al. (2016) report that FP uptake is influenced not only by individual beliefs about and attitudes toward contraceptives, but also by social norms concerning childbearing in marriage, spacing of pregnancies, and women's (often constrained) ability to act on their own decisions. Thus, as discussed above, understanding social norms that influence behavioral intentions and actions is critical to effective messaging and programming for FP interventions.

STUDY GOAL

The goal of this assessment is to provide evidence to inform the development of USAID/South Sudan's SBC efforts related to increasing voluntary use of FP/RH care, awareness of GBV, and health-seeking behavior. This assessment investigated social norms related to FP choice and decision-making, MHM, attitudes towards GBV, and decisions related to health-seeking behavior. Information was also gathered on influencers and gatekeepers of social

Figure 2. Theory of Planned Behavior



⁵ The South Sudan National Family Planning Policy (2013) and the South Sudan Reproductive Health Policy (2019–2029) provide policy/legality on FP in South Sudan. However, violence against FP providers and users continues due to the limited awareness about the policy and the relatively weak institutional framework to facilitate effective implementation of the FP/RH policies.

norms in South Sudan. The study provides rich insights into the contexts of the five sites where data were collected, and findings will inform SBC activities in South Sudan.

RESEARCH THEMES FOR INVESTIGATION

The following research themes (areas of investigation) guided the data collection to provide an evidence base to inform SBC design, programming, messaging, and monitoring and evaluation:

- 1) Understanding of the sample population's knowledge, attitudes, and perceptions that influence FP/RH, GBV, health-seeking behaviors and practices, and how these may vary across demographic factors (e.g., age, marital status, sex).
- 2) Social norms (injunctive and descriptive) that influence individuals' and couples' attitudes and intentions around FP/RH, GBV, and health-seeking behaviors, and how they facilitate or limit these behaviors.
- 3) Identification of the key influencers, including religious leaders, traditional leaders/elders, and health care providers, and their perceptions and beliefs towards FP/RH and GBV.
- 4) Other factors that influence a target audience's intentions, attitudes, behaviors, and norms around FP use, GBV, and family health (e.g., structural factors relating to access, violence, and conflict).

STUDY METHODOLOGY

STUDY DESIGN

This was a cross-sectional, descriptive assessment that utilized qualitative methods of inquiry to promote an in-depth understanding of social norms in South Sudan and how women and men think about FP/RH and GBV, and to better understand how decisions are made about the use of FP and related health-seeking behavior. Data collection included stakeholder KIIs and IDIs, with the study population being asked to respond to fictional vignettes about individuals facing situations related to FP/RH and GBV. This included adapted activities found in the Social Norms Exploration Tool (SNET) (Institute for Reproductive Health 2020), which was developed specifically to support identifying social norms that drive targeted behaviors. In addition, MIHR included selected questions from the Reproductive Empowerment Scale developed by MEASURE Evaluation (Mandal & Albert 2020), as well as adaptations from vignettes in CARE's Journey Piloting Social Norms Measures for Gender Programming Report (CARE USA 2017). All vignette questions focused on fictitious South Sudanese subjects.

Public health precautions: Due to COVID-19, additional safety precautions were used to protect the data collectors, study respondents, and others involved in the study. This included the use of personal protective equipment (PPE), appropriate social distancing, and conducting interviews outdoors as much as possible. No group activities were convened as part of data collection for this study.

STUDY SITES AND STUDY POPULATION

The assessment was conducted in five South Sudanese counties that were identified in collaboration with USAID/South Sudan. Participants were recruited from selected rural and urban *payams*⁶ (see Table 3 for details).

The study population within each study location included: a) women and men, aged 15⁷–24 and 25–49 years, who were married and unmarried; b) FP/RH care providers; and c) key influencers.

Table 3. Study Sites

	County	Urban Payams	Rural Payams
1	Bor County	Bor	Kolnyang, Makuach
2	Leer County	Leer, Juong	Pilieny, Payah
3	Budi County	Komori	Nagishot, Luodo, Lotukei
4	Wau County	Wau North, Wau South	Besselia
5	Yambio County	Yambio Town	Ri-Rongu, Gangura, Bangasu, Bazungua

SAMPLING DESIGN AND STUDY SAMPLE

Prior to initiating data collection within the study sites, KIIs were conducted with USAID/South Sudan staff and health implementing partners, including Intra-Health and Breakthrough ACTION. The KIIs elaborated on study sites to consider categories of potential study participants, locations frequented by potential study participants, and who the key influencers were in these locations. Vignettes were also reviewed by these stakeholders to ensure they aligned with the context and communities where IDI respondents were to be interviewed.

A purposive sample of married and unmarried women and men aged 15–24 and 25–49 years, FP/RH health care providers, and key influencers were selected. FP/RH providers were identified at facilities within each study site where FP/RH services are provided. Additional key influencers to interview were identified through the stakeholder KIIs, and also through the IDIs with women and men through their responses to the vignettes.

In total, 120 women and 83 men, 34 FP/RH providers (16 women and 18 men), 31 key influencers (10 women and 21 men) (see Table 4), and 7 stakeholders were recruited for this assessment. A significant percentage of the respondents (32.48 percent) among community members and key influencers did not have any formal education; 29.91 percent obtained some primary education, while 12.82 percent had attained some secondary and post-secondary education (see Appendix Three, Table 7). Almost half (46.9 percent) of the FP providers interviewed were nurses, while 28.1 percent were midwives. An

⁶ An administrative level just below the county level.

⁷ Fifteen-year-old respondents were only interviewed if they were married. Regardless of age, if married, South Sudan views them as adults; therefore, they are considered able to provide consent. If unmarried, and less than 18 years old, they were considered minors for this assessment, and both consent and assent were sought.

equal proportion of doctors and community health workers (CHWs) (12.5 percent each) were also recruited (Appendix Three, Table 8).

Table 4. Assessment Respondents

Sample Population	Sex		Total
	Female	Male	
Women and men (ages 15–24 and 25–49 years, married and unmarried)	120	83	203
Key influencers	10	21	31
Primary health care workers	16	18	34

DATA COLLECTION METHODS

Stakeholder interviews: Data collection began with stakeholder interviews with USAID/South Sudan, Intra-Health, and Breakthrough ACTION staff to collect information about data collection sites, and to refine and further develop the data collection tools and processes, including any selection criteria for study participants. These interviews were conducted through web conferencing due to COVID-19 concerns.

IDIs with younger and older women and men of reproductive age (15–49 years): In each site, in-depth interviews were conducted with each population sub-group of interest (unmarried and married women and men aged 15–24 and 25–49). The interviews included collecting demographic information on the respondents, and responses to vignettes to elicit information on social norms. Additionally, Likert scale questions⁸ were asked of all respondents to allow comparisons across groups.

IDIs with FP/RH providers at select facilities: IDIs were held with FP/RH health providers to explore existing behaviors, practices, social norms, biases, and perceptions among providers that affect FP/RH and GBV counseling services, and respectful care (including facilitators and barriers). Likert scale questions, similar to those asked of community members, were asked of FP/RH providers, to compare their views to community respondent views.

IDIs with key influencers: Through stakeholder interviews and other IDIs, key influencers were identified. The study used vignettes to examine informants’ perceptions about the role they play in influencing women’s and couple’s decision-making regarding FP/RH, childbearing, spacing pregnancies, use of modern contraceptives, GBV, and decision-making related to health seeking. Likert scale questions were also asked of key influencers.

DATA ANALYSIS

Data analysis began with daily end-of-day debriefs with the team lead and field manager to identify key themes discovered during the day. These were captured in notes and MS Excel sheets for later sorting as analysis continued iteratively throughout data collection. This was followed by translation

⁸ Likert scale questions asked the respondent to rate an issue from “strongly agree” to “strongly disagree.”

and verbatim transcription of the interviews. For quality control, the field manager reviewed selected transcripts against the audio recording.

The co-principal investigators (co-PIs) reviewed the first end-of-day debriefs to provide feedback on additional areas to explore or probe, based on the information gathered. Data transcriptions were also reviewed periodically by one of the co-PIs. Additionally, the research management team held weekly meetings to discuss ongoing successes and challenges during data collection and analysis.

At the end of the data collection, an online meeting with the research management team provided an opportunity to begin synthesizing themes that could be used to code interviews. The research team developed a preliminary codebook using thematic coding derived from questions in the data collection tools for the various respondent categories. Selected members of the research team continued to contribute to data analysis through open and axial coding, and analysis of data using Dedoose (www.dedoose.com), an online, low-cost, qualitative data analysis software package. Dedoose allows multiple coders to work collaboratively from remote locations, promoting triangulation of findings.

Once all data were coded, further analysis was guided by the assessment questions for an in-depth exploration of the information emerging from the various codes. Additionally, data analysis explored potential differences in responses among participants of different ethnicities, sexes, marital statuses, ages, and locations. Following data analysis, information under related codes was merged into larger themes and sub-themes, which are presented in subsequent sections in this report.

DATA MANAGEMENT

Data were managed in password-protected cloud platforms (Kobo Toolbox and Dedoose) that were encrypted for data security. The password was given to a limited number of staff who needed access to the data during data analysis and reporting. Information on each study participant was stored with a discrete individual code in a password-protected Excel sheet to which only those doing data analysis had access.

During data collection, data were recorded on an electronic device (tablet) used by each research assistant. After transcription of the recordings, the team cleaned the transcripts to ensure all personal information was protected by replacing names and personal identifying information with the discrete code assigned to each individual study participant.

ETHICAL CONSIDERATIONS

Human subject protection for this assessment was based on principles of the Belmont Report,⁹ which is the basis of the U.S. Federal Policy for the Protection of Human Subjects,¹⁰ also referred to as the “Common Rule.” The protocol for this assessment was reviewed and approved by a U.S.-based institutional review board (IRB) through John Snow, Incorporated. To ensure an ethical review process in South Sudan, MIHR convened an in-country technical review panel. Members of the panel

⁹ Belmont Report: <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html>.

¹⁰ Common Rule: <https://www.hhs.gov/ohrp/regulations-and-policy/regulations/common-rule/index.html>.

were South Sudanese professionals with a background in FP/RH and/or research, and had no prior association with MIHR. Following an online course on research ethics, panel members reviewed the assessment protocols and provided clearance for the assessment to move forward.

As part of the informed consent process prior to every interview, the interviewer introduced himself/herself, described the purpose of the study and interview, read a statement on confidentiality and on voluntary participation, and provided contact information for any concerns about the study. Participants were then asked to consent to be interviewed by providing written consent or by providing a thumbprint if unable to read or write.

Study participants were only asked about what they thought about the fictitious scenarios presented in the vignettes, not about their personal experiences related to FP/RH or GBV, potentially limiting any discomfort or awkwardness with the questions. All interviewers received training on how to facilitate interviews that could elicit sensitive information. As needed, interviewers referred study participants to reliable sources of FP and/or services for GBV within a reasonable travel distance, whenever they were asked.

STUDY LIMITATIONS

Due to public health precautions, focus group discussions, which were part of the original protocol, were not conducted. Focus group discussions would have provided interaction between respondents that the IDIs did not. However, this did not affect the data validation since the study targeted several categories of participants differentiated by age, marital status, position, and location.

Given the use of vignettes about fictitious individuals, the study did not ask about personal practices or experiences. Therefore, the study was not able to estimate prevalence of contraceptive use, experiences related to GBV, or use of services.

STUDY FINDINGS

This section presents findings on social norms, attitudes, beliefs, and practices related to FP/RH choice and decision-making, health-seeking behavior, sexual debut, MHM, and GBV. These findings are focused on the reported social norms, and not necessarily what people do or practice. Information on influencers and gatekeepers of social norms and their perceptions and beliefs is included. Other factors that influence intentions, attitudes, behaviors, and norms around FP use and family health are also described. Findings presented were similar across all sites, unless otherwise noted.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

SOCIAL NORMS ON MODERN CONTRACEPTIVES USE

Childbearing

Study findings show that it is culturally appropriate to expect that women whose bride price was paid should therefore produce many children. Interviews with influencers indicate that this is meant to compensate for the material things provided to the bride's family. Several men reiterated that use of modern contraceptives signifies that resources for the bride price were wasted. They observed that the man's family can reclaim the bride price if a woman chooses to use contraceptives.

"His family will be upset... this is because they have taken cows from her husband with the hope that she will produce kids for him." Female key influencer, rural payam, Bor County

"He should go to her family and reclaim his cows that he paid as dowry, because in our culture a man marries to produce children." Male key influencer, rural payam, Leer County

"The communities believe that they marry with so many cows, and so she is supposed to produce many children as a pay-back for the dowry paid." Female key influencer, urban payam, Wau County

According to the findings, it is culturally appropriate to expect married women to fulfill their biological roles by bearing children. Some participants linked this obligation to the Christian Bible, which urges humans to "go fill the world." Several men noted that women have to bear many children, since South Sudan has plenty of land that can accommodate a larger population.

"A woman is supposed to produce many children for the family... that is why God gave her the ability to get pregnant and not the man." Male key influencer, rural payam, Yambio County

"In South Sudan, people need to produce children in plenty; we have the land, and we need people to utilize it." Married man, 25+ years, urban payam, Bor County

"The Bible itself says that the woman should produce children to fill the earth." Male religious leader, rural payam, Yambio County

"That is what we were created to do, we are supposed to bring children to this world... so when you get a man, you are expected to produce children." Married woman, less than 25 years, urban payam, Budi County

Discussions with participants revealed that the onset of menstruation means that girls are ready to have children. Therefore, onset of menses signifies fertility of a girl and a transition from being a girl to being a woman, ready to become a mother and bear children.

"The community is positive about menstrual blood. They believe that a girl is ready to produce children." Female key influencer, rural payam, Leer County

“People believe that when one gets menstrual blood, she has reached a stage at which she is ready to produce children.” Married man, 25+ years, urban payam, Yambio County

“The moment you see that blood, then know that this girl’s body is ready for children. You will see people celebrating when this happens.” Unmarried man, less than 25 years, rural payam, Wau County

Contraceptive Use

Study findings show that it is not culturally appropriate or acceptable for women and girls to use modern contraceptives, especially without her husband’s consent. Interview participants across all categories reiterated that use of contraceptives is prohibited in their communities. Some participants related modern contraceptive use to having an abortion, going against the natural gift of producing children, a criminal offense, falling out of love with their partner, going against a Biblical commandment to “go fill the world” as noted above, and committing a sin. Other participants argued that modern contraceptive use is a foreign practice being advocated to achieve the selfish interests of outsiders.¹¹ Some male FP providers noted that modern contraceptive use prevents the replacement of men and women that were lost in war. In this case, some providers mirror the same norms as those in the community. Generally, the negative perceptions around use of modern contraception tends to be based on expectations related to women’s and girls’ gender roles, which can affect the use of modern contraceptives.

“The use of contraception is not acceptable in the community. God made a woman to give birth, so why would a woman take something that stops her from producing.” Male key influencer, rural payam, Yambio County

“Contraceptive use is not supported; when a woman gets married, she should give birth to many children and fill the world. Even the Bible asks for the world to be filled with many people, and other people keep dying, so the children produced replace the people dying.” Female key influencer, rural payam, Leer County

“We have lost a lot of people in South Sudan, we do not need contraceptives, and we need to repopulate our land.” Male FP provider, rural payam, Wau County

“In our culture as Jieng (Dinka), we do not have such things and we do not support them. If the girl learns to take these drugs (modern contraceptives) to prevent pregnancy, they will have difficulty conceiving, she will bleed heavily, and it encourages prostitution. So, we do not accept the use of contraceptives by girls in our community.” Female key influencer, urban payam, Bor County

The findings show that female and male community members held similar sentiments in this regard. Some married women expressed that “God” does not bless girls that use contraceptives. They urged adults that learn about young girls wanting or using contraceptives, or that are consulted, to immediately inform the girl’s caretakers. Notably, a few participants did accept condom use, arguing

¹¹ In some circles, there is a belief/myth that outsiders, especially from some of the Western powers, have hidden agendas behind the push for contraception, e.g., to limit population growth for South Sudanese.

that it does not present reproductive challenges. Some men in urban field sites in Wau encouraged contraceptive use among adolescent girls, but not adult women. A female service provider in Yambio willingly provides modern contraceptives to young girls but not adult women, out of fear of being violently attacked by their spouses.

“A neighbor with a good heart will come and tell the parents that there is some behavior that I saw your daughter/son doing, which is not good.” Married man, 25+ years, urban payam, Bor County

“They should not use contraception because they are still young. What they can use are condoms because this does not in any way affect their ability to produce.” Married woman, 25+ years, urban payam, Leer County

“I have no problem providing contraceptives to girls aged 14–16, I find problems providing them to married women. I totally refuse if the man has not accepted her to use. They might attack me when they find out.” Female FP provider, urban payam, Yambio County

“I have thought about this a lot of time, I think it is okay for those young girls to use those things [contraceptives]... they are not married, they are not expected to have children as those that have husbands, yet their bodies might demand for something [sex] so for them it is okay, but not for those that are married because they are expected to have children.” Married man, 25+ years, urban payam, Wau County

Findings show that adolescents who use modern contraceptives are labelled as undisciplined, spoiled,¹² criminals, bad, and promiscuous. Participants noted that parents discriminate against such children, often calling for their punishment. It was reported that families of minors using contraceptives lose their honor and/or social status.

“This means that these children are undisciplined because they should not use contraception and are having sex before marriage.” Married woman, 25+years, rural payam, Leer County

“Those are criminals that need to be dealt with, and their families too, who can respect such a family?” Married man, 25+ years, urban payam, Wau County

“The moment they get to know, they will be very annoyed, they will see you as spoiled, someone that shall spoil others.” Unmarried woman, less than 25 years, urban payam, Budi County

Child Spacing

Study findings show that in Wau, Bor, and Budi, the social norm is that married couples should abstain from sex for 2–3 years after childbirth. Discussions with participants reveal that this is meant to achieve spacing of pregnancies. A community leader from Budi reported that men who fail to abstain from sex with wives who recently gave birth are mocked, laughed at, and shamed.

¹² In this context, respondents indicated that “spoiled” means poorly behaved or not well-mannered in the context of community norms.

“One has to abstain from sex for 2-3 years after birth of a child. As soon as the wife delivers, the couple abstains from sex until the child is 2 years and above. Communally, a man is not allowed to have sex with his wife during this period, for those who tempt to have sex before 2 years elapse, they are mocked, undermined, and discouraged by the society through community talks and locally composed songs that humiliate and shame those men.” Female key influencer, rural payam, Budi County

“Contraception is totally a foreign concept, and the communities prefer to use their natural ways of birth control.” Male key influencer, rural payam, Bor County

During the data validation meeting, it was noted by participants that the practice of postpartum abstinence may not be common currently, but points to the reality that traditional methods of FP are cherished in some communities. This too demonstrates that the value of child spacing and its relationship to healthy children or child well-being is prevalent in the community. The tension may be on how to achieve this value given that use of modern contraception is not yet widely accepted as a norm in the communities visited for this study. It is imperative to note that although this norm of postpartum abstinence may be a resource in promoting child spacing in the context of particularly traditional FP, it needs to be treated with caution, given that it is being practiced in the context of social norms that accept and tolerate polygamy. This norm also should be considered in the context of the SRH rights of women, and to ensure adherence to “do-no-harm” principles and gender equity.

EMERGING SUPPORTIVE NORMS AND/OR NEGOTIATIONS

Responses to vignettes about attending school and wanting to delay pregnancy show that positive or alternative norms, attitudes, beliefs, and practices are beginning to emerge, mainly among communities in urban payams and by unmarried young and older persons, to challenge restrictive social norms related to modern contraceptive use. Some participants identified birth spacing, reducing unintended pregnancies, controlling family size, improving child health, ability to invest in a child’s well-being, and school continuation as benefits of modern contraceptive use. Some younger adults and some FP providers emphasized the role of contraceptives in school completion.

“She does not want more children; she did that because she wants to have child spacing that may help her to manage her family and put her two children into good schools. Family planning is the best way to achieve child spacing and manage a family.” Unmarried man, 25+ years, urban payam, Leer County

“She wants to space her children... continuous births bring about problems. Sometimes if the woman conceives when the other baby is still young, it might die because of improper care.” Unmarried woman, 25+ years, urban payam, Wau County

“I will tell her, ‘my daughter, producing too many children like this is also not good... NGOs (nongovernmental organizations) and the government brought contraception so that you can protect yourself... so that your two children can join school and you can look after them well. Then if one child is going to P-3 [primary school, 3rd level], then let the other one be going to nursery.’” Married woman, 25+years, urban payam, Yambio County

Although the assessment did not ask directly about respondents' knowledge of modern contraceptives, some persons, mainly in urban payams, identified various types of modern contraceptives available in their communities, while others, mainly in rural payams, had limited awareness and knowledge of modern contraceptives.

“There are many types... one is condom, then tablets, which should be got from the hospital because there they will tell them how they are used and the side effects. I would prefer them to use tablets, but it may affect the young girl.” Married woman, 25+ years, urban payam, Wau County

“There are women in this community that have never heard of contraceptives and don't know how they work.” Married woman, 25+ years, rural payam, Budi County

The respondents also identified traditional contraceptive methods, including withdrawal and herbs. In a rural community of Bangasu, Yambio, local herbs are used to space and prevent conception (pregnancies). There appears to be a lack of knowledge of the efficacy of traditional methods, yet the intention to use a contraceptive may provide a foundation for uptake of modern contraceptives.

“If a woman wanted to space her children, she would have to first inform the family, and the herb would be prepared for her to take. There was another onion-like herb that when taken would stop her from producing completely.” Local chief, rural payam, Yambio County

“One can use withdrawal tactic when having sex. For withdrawal tactic, a man ejaculates outside but not inside the vagina.” Unmarried man, less than 25 years, urban payam, Bor County

Discussions revealed a preference for given methods and particular providers. Several participants (community members and FP providers) identified condoms as the most popular method among young people, albeit perceiving those that use them as “spoiled” (i.e., poorly behaved or ill-mannered). They explained that condoms are easy to access, have no side effects, and can easily be used in secrecy by the couple without others noticing or getting suspicious that they are using contraception. Interviews with FP providers revealed that married women preferred relatively long-acting contraceptives such as injectable contraceptives, as opposed to pills that are taken daily. They explained that it was harder for partners to notice that they were using injectables. However, some FP providers, particularly in Wau, were skeptical about providing long-acting and reversible contraceptive (LARC) options, arguing that protracted periods without conceiving arouses the suspicion of contraceptive use, especially when contraception is used without knowledge and consent of the spouse and other key influencers

“They can use condoms so that their family doesn't notice or even their friends, because a condom is something that can be used and then thrown away.” Unmarried man, less than 25 years, urban payam, Bor County

“Depending on the woman's condition, I can provide, but not long-term like implants... because when men see that a woman is not getting pregnant, they will start being touchy, trying to find out if the women have implants and if they find it, that brings about problems.” Female FP provider, urban payam, Wau County

“For example, condoms are mostly used by these boys, you know, these children of nowadays are spoiled.” Married man, 25+ years, urban payam, Leer County

Respondents discussed who influences their health decisions, and the unalienable role of community influencers (including parents, men, elders, community leaders) in the uptake of FP services.

“Children love and listen to their parents more than any other person... communities of Wau only trust their own people. Most parents do not allow anyone outside the family to advise their daughter, as they think other people may advise out of jealousy and may provide wrong advice on contraceptive use which could have devastating side effects to their child... working with people that communities trust is important.” Male key influencer, urban payam, Wau County

“Community leaders can advise on health issues in the community, and other elders are also able to add a voice. We have seen them work in other interventions.” Male FP provider, rural payam, Leer County

Discussions with FP providers reveal that community and school outreach is limited to information sharing and not provision of modern contraceptives. This is mainly due to a fear of backlash. This provides health workers with an opportunity to address misinformation; however, they miss out on recruiting early adopters for contraceptives.

“My colleagues and I... normally go out for outreach especially in schools, but all we do is talk about contraceptives and never provide any out of the fear that I have already explained. So we miss out on those people that are willing to start using.” Female FP provider, urban payam, Wau County

PATIENT-PROVIDER COMMUNICATION ON FAMILY PLANNING

Community Perspectives

The study also collected quantitative information using Likert scales on patient-provider communication on modern contraception. A response to each of the statements was either agree, disagree, strongly agree, or strongly disagree.

Overall, a substantial proportion of women (17.2 percent) and men (37.1 percent) disagreed with the statement, “A woman can initiate a conversation on contraceptive use with her health care provider,” with men disagreeing with this statement at more than twice the percentage of women. When disaggregated by location, more participants in rural (27.9 percent) than urban areas (24.6 percent) disagreed with the statement. When asked if a woman and her health care provider typically talk about using contraception, more men (37.1 percent) than women (16.4 percent) disagreed with the statement. When disaggregated by location, more participants in rural (28.8 percent) than urban (22.95 percent) areas disagreed with the same statement (Table 5). Note that “Rose” is the fictitious character from the vignettes.

Table 5. Patient–Provider Communication: Community Perspectives

Respondent	Agree		Disagree		Do Not Know	
	n	Percentage	n	Percentage	n	Percentage
1. Rose and her health care provider talk about using contraception.						
All (N=233)	148	63.52	60	25.75	25	10.73
Female (n=128)	85	66.41	21	16.41	22	17.19
Male (n=105)	63	60	39	37.14	3	2.86
Urban (n=122)	85	69.67	28	22.95	9	7.38
Rural (n=111)	63	56.76	32	28.83	16	14.41
2. Rose can initiate conversations about using contraception with her health care providers.						
All (N=233)	145	62.23	61	26.18	27	11.59
Female (n=128)	83	64.84	22	17.19	23	17.97
Male (n=105)	62	59.05	39	37.14	4	3.81
Urban (n=122)	81	66.39	30	24.59	11	9.02
Rural (n=111)	64	57.66	31	27.93	16	14.41
3. Rose can ask her health care provider questions about using contraception.						
All (N=233)	163	69.96	40	17.17	30	12.88
Female (n=128)	92	71.88	15	11.72	21	16.41
Male (n=105)	71	67.62	25	23.81	9	8.57
Urban (n=122)	93	76.23	20	16.39	9	7.38
Rural (n=111)	70	63.06	20	18.02	21	18.92
4. Rose can share her opinions about using contraception with her health care providers.						
All (N=233)	163	69.96	38	16.31	32	13.73
Female (n=128)	89	69.53	14	10.94	25	19.53
Male (n=105)	74	70.48	24	22.86	7	6.67
Urban (n=122)	92	75.41	19	15.57	11	9.02
Rural (n=111)	71	63.96	19	17.12	21	18.92
5. When discussing contraception with her health care provider, she/he pays attention to what Rose has to say.						
All (N=233)	180	77.25	22	9.44	31	13.30
Female (n=128)	96	75	7	5.47	25	19.53
Male (n=105)	84	80	15	14.29	6	5.71
Urban (n=122)	99	81.15	12	9.84	11	9.02
Rural (n=111)	81	72.97	10	9.01	20	18.02

Family Planning Provider’s Perspectives

FP providers were asked about patient-provider communication. Response choices were agree, disagree, strongly agree, or strongly disagree. Most males (82.35 percent) agreed that unmarried young women in the age group of 14–16 years and their health care providers talk about using contraception, while somewhat fewer females (73.33 percent) agreed with the same statement. When FP providers were asked about the statement, “Married young women (14–16) and their health care provider talk about using contraception,” almost an equal proportion of the females (80 percent) and the males (82.35 percent) agreed. The results in Table 6 show that all females (100 percent) and a majority of males (82.35 percent) agreed that adult women and their health care provider talk about

using contraception. All male and female FP providers agreed that women can share their opinion about using contraception with their health care provider. Table 6 shows that all females (100 percent) and majority of males (94.12 percent) agreed that when discussing contraception with their health care provider, women and men pay attention.

Table 6. Patient–Provider Communication: Providers Perspectives

Respondent	Agree		Disagree		Do Not Know	
	n	Percentage	n	Percentage	n	Percentage
1. Unmarried young women (14–16 yrs.) and their health care provider talk about using contraception.						
All (N=32)	25	78.13	7	21.88	0	0.00
Female (n=15)	11	73.33	4	26.67	0	0.00
Male (n=17)	14	82.35	3	17.65	0	0.00
Urban (n=14)	12	85.71	2	14.29	0	0.00
Rural (n=18)	13	72.22	5	27.78	0	0.00
2. Married young women (14–16 yrs.) and their health care provider talk about using contraception.						
All (N=32)	26	81.25	6	18.75	0	0.00
Female (n=15)	12	80	3	20.00	0	0.00
Male (n=17)	14	82.35	3	17.65	0	0.00
Urban (n=14)	12	85.71	2	14.29	0	0.00
Rural (n=18)	14	77.78	4	22.22	0	0.00
3. Adult women and their health care provider talk about using contraception.						
All (N=32)	29	90.63	3	9.38	0	0.00
Female (n=15)	15	100	0	0.00	0	0.00
Male (n=17)	14	82.35	3	17.65	0	0.00
Urban (n=14)	12	85.71	2	14.29	0	0.00
Rural (n=18)	17	94.44	1	5.56	0	0.00
4. Women can initiate conversations about using contraception with their health care.						
All (N=32)	29	90.63	3	9.38	0	0.00
Female (n=15)	15	100.00	0	0.00	0	0.00
Male (n=17)	14	82.35	3	17.65	0	0.00
Urban (n=14)	12	85.71	2	4.29	0	0.00
Rural (n=18)	17	94.44	1	5.56	0	0.00
5. Women can share their opinions about using contraception with their health care.						
All (N=32)	32	100.00	0	0.00	0	0.00
Female (n=15)	15	100.00	0	0.00	0	0.00
Male (n=17)	17	100.00	0	0.00	0	0.00
Urban (n=14)	14	100.00	0	0.00	0	0.00
Rural (n=18)	18	100.00	0	0.00	0	0.00
6. When discussing contraception with her health care provider, he/she pays attention.						
All (N=32)	31	96.88	0	0.00	1	3.13
Female (n=15)	15	100.00	0	0.00	0	0.00
Male (n=17)	16	94.12	0	0.00	1	5.88
Urban (n=14)	13	92.86	0	0.00	1	7.14

Rural (n=18)	18	100.00	0	0.00	0	0.00
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QUALITY OF THE FAMILY PLANNING WORKFORCE

Interviews with FP providers reveal that some health workers have not accessed in-service professional development programs to improve their professional knowledge, competencies, and standards. The implication is that some health workers may be providing out-of-date and contradictory FP information to the clientele. This may be attributed to fewer opportunities available to providers to attend refresher trainings on modern contraception in the study sites.

“We have two types of service providers. One type studied a long time ago, and the other has had a chance to get up-to-date information on family planning. So all of these are providing services to the same population. When one approaches the person that has outdated information, she gets information on modern contraceptives that is in contrast with what their colleague provides.” Female FP provider, urban payam, Yambio County

Misconceptions on Modern Contraceptives

Interviews with FP providers show that misconceptions and limited access to forums where one can address this misinformation has greatly affected uptake of modern contraceptives. It was reported that women and men most affected by misinformation often are not connected with institutions where correct information may be available, such as schools. However, they do have easy access to those that are more likely to provide incomplete or inaccurate information (e.g., traditional birth attendants).

“There is a lot of wrong information on contraceptives. Unfortunately, we have not been able to address the issue of this wrong information, so we need to see this happen.” Male FP provider, urban payam, Wau County

Interviews with some of the key influencers further confirmed that misinformation, particularly in relation to side effects of modern contraception, is prevalent in the study communities.

“There are complications that she will experience after receiving the injection, it affects menstruation, so how will one reproduce in the future when menstruation stops completely?” Female key influencer, rural payam, Bor County

Other factors discussed by interviewees included the discriminative practices toward persons that use contraceptives; limited or no knowledge of contraceptives; unavailability of FP service points; and long distances to available service points. Respondents noted that the majority of the service points are in urban locations.

“Many people do not know what it [FP] is about; the moment they see one [FP user] from the clinic they get annoyed towards that person.” Unmarried woman, less than 25 years, rural payam, Leer County

“Community education on family planning is low... if we are to progress further, this needs to be intensified.” Male FP provider, urban payam, Budi County

EARLY MARRIAGE

AGE AT MARRIAGE

Some respondents, mainly in rural payams, indicated that it is most appropriate for girls to get married at the age they start menstruating. Some older and younger married interviewees talked of a correct and reasonable age. This varied, ranging from 14 years up to 20+ years. Mainly those who had attained a secondary or higher level of education indicated that persons below the age of 18 should not get married.

“A girl who reaches the age of 14 to 15 years is right to get married here in our community.” Married woman, 25+ years, rural payam, Leer County

“Sometimes, a girl can get her menses at the age of 14 but still can’t be ready for marriage. However, when she gets to the age of 16 or 17, she is then ready for marriage.” Married man, 25+ years, urban payam, Bor County

“I think [woman’s name] should get married at a reasonable age. When [she] reaches 20 years and above, then she is free to get married, but from 10 to 18 she should not get married because she is still young.” Married man, 25+ years, urban payam, Wau County

Study findings reveal that structural stressors (e.g., conflict, aid dependency) resulted in an upward shift in age at marriage for men less than 25 years. Married men explained that conflict destroys livelihoods and undermines the development prospects of young men. Some are no longer able to raise the bride price at an early age. These findings are in line with the study conducted by United States Institute of Peace (2011) that also found increasing inability of male youth to meet dowry demands that include payment in terms of cows in some communities and a relatively high amount of cash.

“Long time ago, by that age the boys would have built their home, the harvests were much better, but now things have changed... so they cannot afford to marry early, the conflict disrupted everything.” Male key influencer, urban payam, Wau County

Some respondents who had attained secondary or post-secondary education observed that it is most appropriate to marry when one completes their education, whether secondary or post-secondary. They expressed that, at this stage, one is capable of looking after a family.

They also discussed that girls should marry at the age when they are less likely to experience complications in labor and delivery.

“It is best if she first finishes school, then she will be able to look after her family.” Married man, 25+ years, urban payam, Budi County

“When a girl finishes secondary school and she says, ‘dad, I am going to get married,’ he cannot refuse. She will be able to engage in activities that can help her manage her family well.” Unmarried woman, less than 25 years, urban payam, Wau County

“Yes, ages like 12, 13, and 17... she will face difficulties while giving birth. She may even give birth through operation.” Unmarried woman, less than 25 years, urban payam, Wau County

SOCIAL NORMS ON EARLY MARRIAGE

Study findings show that it is culturally appropriate for girls who have started menstruating to get married. Discussions with several older, married participants indicate that the onset of menstruation signifies maturity and readiness for marriage, marks that the family is about to receive a bride price, and that the family can start looking for her spouse. In preparation for their “giveaway,” the girls are provided with particular body-building foods¹³ and make changes in the way they dress to communicate to the wider community that she has turned into a woman.

“When a girl has her first menses, the mother goes to the market to buy her new dresses and underwear. They make her wear things of an adult to send a message that she is no longer a child but a woman.” Married man, 25+ years, rural payam, Wau County

“In this community, when the girl experiences menses, she is eligible for marriage. It is also a sign that you are about to get dowry.” Married man, 25+ years, urban payam, Bor County

“With regard to menstruation, when a lady starts her menses, it is perceived that she has started looking for men and will be considered ready for marriage.” Married man, 25+ years, rural payam, Yambio County

“Yeah, there is special consideration from parents. For example, she will be given special food to eat so that she builds her body and is made ready for marriage.” Unmarried woman, less than 25 years, rural payam, Bor County

“Moreover, when a man approaches her, he will be allowed to talk to her about her older sisters since they know she is a mature lady.” Married woman, 25+ years, urban payam, Bor County

Some older and younger women, mainly in urban payams, argued that first menses does not signify readiness for marriage. Some participants perceived it simply to be a sign from “God” that one can have children. They explained that one can delay marriage for many more years.

“That is not what it means, you can have your menses today and still stay for years before getting married.” Unmarried woman, less than 25 years, urban payam, Bor County

“Menstruation does not mean she is mature enough to get married, because even if her womb is not yet expanded to keep a baby, but God is just showing people that she will produce.” Married woman, 25+ years, urban payam, Leer County

¹³ For example, eggs and legumes.

“In our culture, it does not signify maturity, the girl is not yet mature, the bones such as pelvic and other nerves are not mature.” Male key influencer, rural payam, Bor County

“The girl’s period is not indication that she is ready for marriage. Some see their periods when they are thirteen years old, while others could be sixteen years. Even if the girl sees her period at sixteen, there are many things in her body which are not mature. This girl cannot bear the pregnancy if she conceives, she will be at risk of death following birth complications.” Female key influencer, urban payam, Bor County

Findings also show that it is typical of girls who have their first period to gain social status as a woman. Discussions with older, married women show that menses signify transition into womanhood or adulthood. It was noted that girls who have begun menstruating are highly respected by the elders and are no longer treated as children.

“Yes. It shows that she is changing from being a girl to being a woman.” Married woman, 25+ years, rural payam, Wau County

“In our community, if people learn that a girl has started her menses, she will not be treated as a child anymore and will be highly respected.” Married woman, 25+ years, urban payam, Leer County

“It is a belief that when the girl sees her menses, she has joined the mature women, she should not play with the boys anyhow because she may be tempted to have sex with the boys, which is not acceptable by the culture.” Male key influencer, rural payam, Bor County

Study findings show that it is typical of men (fathers) to decide when to marry off their daughters. The child is not involved in the decision-making, but is informed of the decision. Further, no one is expected to go against the father’s decision. A respondent noted that often a brother influences the parent’s decision. This is done out of self-interest. The brother can use the incoming bride wealth to in turn secure his own partner’s hand in marriage.

“The father decides on when this shall happen, and no one can object their decision.” Male key influencer, urban payam, Bor County

However, a female key influencer in an urban township discussed that it is the woman who is supposed to choose whom to marry, not her parents.

“Of course, it’s her who should do that, she should be the one, to whomever she feels is the right person in terms of the person loving her, that’s the person she should get married to.” Female key influencer, urban payam, Budi County

Some key influencers, mainly in Wau urban payams, reported that some fathers advise men that are asking for their daughters’ hand in marriage to wait until the daughter completes her education.

Further, they indicated that legal punitive actions are brought against parents that marry off their daughters early.¹⁴

“They can come saying that they want to marry his daughter and he will tell them that they let her first study; they should come back when she has completed school.” Female key influencer, urban payam, Wau County

“Early marriage is strongly discouraged; it should be 18 and above, and the chiefs punish according to the laws. But if the case is beyond the capacity of the chief, he refers it to the big court in Wau.” Male key influencer, urban payam, Wau County

Interviews with key influencers in Budi County show that some women are worried about having their daughters marrying early since they have firsthand experience of the challenges that this brings. They added that calls for men to rescind their decisions are never fruitful, as they are blinded by the wealth they are to receive from the son-in-law.

“Most times mothers are more concerned about the age for marrying off their daughters, the reason being that the mothers got married when they were young and they faced a lot of challenges. On the other hand, fathers care less about their daughter’s age for marriage, as they focus more on wealth.” Female key influencer, rural payam, Budi County

FACTORS THAT INFLUENCE EARLY MARRIAGE

Study findings show that girls born to mothers who were married early were also at heightened risk of early marriage. The risk increases yet further if the girl is out of school. Other participants reported that peer pressure and the fear of losing the partner to another girl or woman also compels girls to early marriage.

“The mother went through similar experience... she cannot stand against the idea of having her married off, especially if she dropped out of school.” Married man 25+, rural payam, Bor County

“She can think of getting married at a younger age when her boyfriend confuses her, or when she thinks that she does not want to lose her current man to another woman because she loves him.” Married woman, 25+ years, rural payam, Wau County

The interviewees discussed how bride wealth shapes practices around early marriage. They noted that families view receiving bride wealth as a means to meeting their welfare needs. Some men use the wealth to marry another wife. Similarly, young men use it to pay their own bride price.

“The family, relatives, and neighbors will be happy, the man shall bring a bride price that they can use at home... some men decide to marry another woman since they have what is

¹⁴ The legal age of marriage in South Sudan is 18 years. However, some sources indicate that almost half of girls get married before 18 years. In 2019, there was a case of early marriage in which the South Sudan court ruled against the marriage of girl who was 16 years old. It has been referred to as one of the landmark cases or rulings. For details see: <https://www.reuters.com/article/us-southsudan-women-court-idUSKCN1U42CK>.

required, or the brothers can also marry since they have cows that are needed by the family of their girlfriend.” Male key influencer, rural payam, Leer County

The respondents discussed the role of schools in keeping girls safe from early marriage. Some described school as a space where topics on early marriage are discussed and children are enlightened on its disadvantages. It was reiterated that children who are out of school are at an increased risk of early marriage.

“School is light, because if you don’t study, you can’t see what is ahead, but if a girl is educated, then it is even better; she knows about everything that needs to be done and why she is supposed to keep in school.” Female key influencer, urban payam, Wau County

Participants also observed that the burden of care compels parents to marry off their daughters. This necessitates looking out for men who can take care of their daughters. Families conduct background checks to ensure that the potential husbands hold the desired qualities. If reviews are favorable, families easily oblige marrying off very young daughters.

“Parents usually do background checks to see if he is from a responsible and wealthy family and whether he has a job, so as their daughter does not suffer. Most families will not marry off their daughters to poor and irresponsible men. Furthermore, they would have no problem giving their daughter into marriage even if she is very young, provided the man is from a wealthy family.” Female key influencer, rural payam, Wau County

MENSTRUAL HYGIENE AND MANAGEMENT

Respondents, mainly key influencers, discussed that menstruation is a natural and normal process.

“Menstruation is not an abnormality, it is something which is natural.” Male key influencer, urban payam, Bor County

“Menstruation is not something bad, but when it comes, she will just bear and live with it, just like that.” Male key influencer, urban payam, Wau County

Younger married and unmarried adults identified mothers, older women, health care providers, peers, relatives, teachers (particularly senior female teachers) and nongovernmental organizations as sources of information on menstruation. It was reported that it is unlikely for a girl to experience her first period with no foreknowledge of menstruation. In schools, it was noted that topics on puberty address menstruation. However, some participants reported that the information provided at schools is inadequate.

“Such things are at times taught at school, and if you are a girl, your mother can even provide you with some basic information at home.” Unmarried woman, less than 25 years, rural payam, Wau County

“If her mother has never explained about it to her or she has never heard anything about it, even at school, then she is likely not to have known anything about it before it happens to her.

But if she was told at school, then she should have known.” Unmarried woman, less than 25 years, urban payam, Yambio County

“When girls are growing, either the mother or the big sisters will have to start having some health education with her so that she can get knowledge about some things and changes that they will begin to experience.” Unmarried man, less than 25 years, urban payam, Leer County

“Sometimes the blood stains the cloth when the girl is not wearing *Always* or pads to protect her from the menstrual blood... that is why a girl is sent to mother, to teach her how to manage her menstruation.” Female key influencer, urban payam, Bor County

Discussions with older and younger adults across study sites revealed that cotton, pieces of cloth, rags, and sanitary pads are some of the menstrual management materials used by girls. In rural areas of Budi, participants identified soft grass as one of the management materials. Some respondents from this community noted that girls do not use any material. In Leer, older and younger adults mentioned softened skin.¹⁵ They also noted that girls in rural communities do not have access to sanitary pads. Participants from rural payams of Wau indicated that girls having their first period are not supposed to use any material. It is believed that if materials are used, the girl shall never have her menses again. In Leer and Bor, some interviewees in rural payams reported that girls sit in cow dung or ash for the time they are menstruating. In Bor, it was also noted that some girls sit on dug holes for the time that they are menstruating.

“Some dig a hole and stay in one place until menses stop.” Married woman, 25+, rural payam, Bor County

“Girls in menses sit on the ash from cow dung for the period she is menstruating; thereafter she goes to the river to wash.” Married woman, less than 25 years, rural payam, Leer County

“In the villages, girls put on skin of a goat, which is made as soft as possible to be worn. Some women and girls use leaves of local trees (*Kan* in Nuer) to manage menses.” Married woman, 25+, urban payam, Leer County

“A girl who receives her menses for the first time does not use anything except water for cleaning herself. In the event that she uses anything, then she will never receive her menses again.” Married woman, 25+, rural payam, Wau County

“A woman in her menses is not allowed to move. She has to sit on ashes made from cow dung during her periods for the blood to flow.” Married woman, 25+, rural payam, Bor County

“They can use *kambus* (a piece of cloth used to cover private parts), and hold it tight with a rope tied around the waist.” Female key influencer, urban payam, Wau County

Respondents, mainly in urban communities, observed that humanitarian agencies provide dignity kits¹⁶ through schools. However, they were uncertain whether distribution was ongoing, given that

¹⁵ Animal skin is hung out to dry, and then is brushed until soft.

¹⁶ These contain hygiene and sanitary items (sanitary pads, underwear, hand soap, toothbrushes, toothpaste, and similar items).

schools are closed due to COVID-19. It was noted that menstrual pads were quite new in some communities (mainly rural communities), and unaffordable or inaccessible to some families. Some participants emphasized that these are to be worn with clean underwear. It was also noted that cloth was the most accessible menstrual management material, and that cloth made from cotton was the best locally available material to manage menses. A participant noted that girls using cotton cloth do not experience a lot of pain during subsequent periods.

“When in the village, they mainly use cloth because they have no access to pads. Within the urban areas, girls have access to *Always*. Most times, the UN and other organizations conduct sensitization on issues of menstruation and also provide pads.” Married woman, urban payam, Leer County

“Cotton cloths are usually provided for the girls to manage menses. Cotton is considered the best and traditional way of managing the blood flow; moreover, a girl will not get a lot of pain in the subsequent periods when she uses cotton.” Married woman, urban payam, Wau County

“The pads are new to us, and we did not have them before. What she will have to do is, the mother will give her a piece of cloth that she will put on after cleaning herself, and then proceed to school.” Unmarried woman, rural payam, Wau County

Study findings show that following the start of the first menses, mothers arrange information sharing sessions for their daughters. In Leer County, it was observed that mothers gather elderly women in the community, who provide advice to the girl having her first period. She is informed that she can now conceive and cautioned to avoid interacting with boys and men. A few participants noted that she is told that she can no longer play with other children when having her period.

“When a girl receives her menses for the first time, the parents of the girl and the elders in the community (mainly women) sit together and advise the young girl. They tell her that she is mature and not supposed to play around with young girls anymore. They tell her to avoid boys because she can easily get pregnant.” Married woman, 25+, rural payam, Leer County

Across study sites, participants observed that mothers organize celebrations or perform rituals when their daughters have their first periods. Celebrations were reported by participants from Leer and Bor. Mothers commemorate the start of menstruation, which signals ability to conceive and attract bride wealth. In the Bongo tribe, the celebration is meant to inform the community that the family has a girl who is ready for marriage. The rituals surrounding the first menses are meant to achieve short and painless periods.

“When a girl gets menses for the first time, the family celebrates because menstruation is an indicator that she can produce children, which is a key factor of marrying her off in this community.” Female key influencer, rural payam, Leer County

“When a girl gets her menses for the first time, they celebrate by slaughtering a goat or a cow, depending on girl’s family wealth status. The celebration is called “*Nyok agugor*” and is made because the girl is now considered an adult, and her menses are a sign that she will produce children and bring wealth to the family.” Married man, 25+, urban payam, Bor County

“Three sticks are broken on her back and those are the days her menses will take.” Female key influencer, rural payam, Yambio County

“People in the community celebrate when a lady gets her menses for the first time. It is a sign that they have a mature lady. The elderly women come and place a ring on the woman as a way of blessing her and welcoming her to womanhood.” Married woman, 25+, rural payam, Bor County

“If the girl experiences her first menses, there are two rituals that are mainly performed: 1) She is washed in the middle of the road in the early morning hours, and 2) The girl is bathed in the middle of the compound, early in the morning using the bark of the tree that spends the whole night in water. Once one of these rituals is performed, the girl’s menses will be shortened and not painful... Some local sticks are used; usually the mother asks the girl to turn her back and they break three strips of this stick on her back. The reason for this is that the menses will only have to last for 3 days... If the menses continues for more than 3 days, then she is taken to her grandmother for additional care.” Married woman, 25+, rural payam, Wau County

Younger married and unmarried adults reported that some girls experience painful periods and were advised to seek medical attention. One participant reported that girls who are weak or in pain are provided with herbal medicine.

“If it comes with pain, then she should ask for permission and go to the hospital.” Unmarried woman, urban payam, Wau County

“There are so many types, there’s traditional treatment that can help someone during her periods, ‘*walai fi*.’ If I find a woman who is weak and unable to walk, then I will bring it to her.” Married woman, less than 25 years, rural payam, Wau County

“Truly, people know that when a girl reaches 13, she will start seeing her menses. And sometimes it comes with heartburn and so much pain. Sometimes the child will just start to cry when it comes with a lot of pain.” Married woman, less than 25 years, urban payam, Bor County

Interviews with older and younger adults show that menstruation hinders participation in school activities. Several participants noted that girls experiencing painful menses often stay at home. Some participants thought that girls with heavy menstrual flow and those with unclean or with no menstrual management materials should not attend school. One participant noted that girls should not attend school on the first day of menstruation.

“She cannot do anything till the end of her menstruation; she should not go to school.” Unmarried woman, less than 25 years, urban payam, Leer County

“If it comes when she is at home then she will not need to go to school until she is okay. You know, at times, menstruation may come with some pain.” Unmarried man, less than 25 years, urban payam, Wau County

“She can continue schooling if at all she is provided with materials that can help her contain the blood. For example, pads. If they are not available, she can stay at home with permission from the school administration.” Married woman, 25+, urban payam, Bor County

“She will not be able to go. When menses start, the girl’s feeling won’t be natural, sometimes it comes with pain, and she can’t be ok with it. There will be fear and she will think about many things like what has happened to me.” Unmarried woman, less than 25 years, rural payam, Wau County

Discussions with younger, unmarried adult women show that girls having their menses can only participate in sports if they do not have menstrual cramps. Some young male adults argued that it is not necessary for them to participate since menstruation increases blood flow and sweating, and causes bad body odor. However, some younger adults contended that it is up to the girl to decide to participate or not.

“Menstruation does not take a long time. It takes 3 to 4 days; one can stay for that period without playing.” Unmarried man, less than 25 years, urban payam, Bor County

“Yeah, she cannot play because it will increase the blood flow. Moreover, she will develop a bad smell in her body as a result of too much sweating.” Unmarried man, less than 25 years, rural payam, Wau County

“It depends on whether she experiences period cramps during her menstruation or not. If she doesn’t experience cramps or has no abdominal pains, then she can be involved in sports activities.” Unmarried woman, less than 25 years, rural payam, Bor County

The study findings show that girls who are menstruating are treated differently. They are exempted from heavy work, not allowed to move in the sun to avoid a heavy menstrual flow, separated from other children, and do not prepare food for men. Notably, girls that start menstruating are encouraged to only interact with men and boys during family events.

“Yes, she would be excluded from heavy work for 3 to 4 days during menstruation. This is because she becomes weak because of bleeding.” Married woman, 25+, rural payam, Leer County

“Yes, she will not be able to participate in heavy work and she will not move under too much sunshine, to avoid heavy bleeding.” Unmarried woman, less than 25 years, rural payam, Yambio County

“There are activities that she should not participate in. She should not be close to boys or men. But if it is a normal family event, then it is okay.” Unmarried man, less than 25 years, urban payam, Bor County

“Menstruating women are considered to be dirty. Once a lady is in her menses, she is not supposed to eat with her fellow women. In South Sudan, all people eat from one tray together, but when a lady is in her menses; she is given her own plate of food, she cannot share with the rest of the women.” Female key influencer, rural payam, Wau County

Participants from Leer and Bor noted that girls who are menstruating are prohibited from certain practices. They are forbidden from drinking milk from cows, do not collect cow dung, cannot use cow dung ash to brush their teeth, cannot serve food to elders, and can only milk one cow following the performance of certain rituals. Taking milk from several cows means that the girl will only attract a small number of cattle as bride wealth.

“It’s very bad for the brother to know that the sister is on her menses, she will always be beaten up.” Female, married 25+ rural payam, Yambio County

“Girls in menses only take milk from the goats and sheep, not cows, because if she takes milk from a cow, she will not be married with many cows... also, she cannot collect dry cow dung and cannot brush with ash from the cow... neither can she give elders food.” Married man, 25+, rural payam, Leer County

“During school, a girl may not be able to attend because of the blending. School boys mock the girls who are in menses if they notice so especially with the blood strains.” Female, married 25+, urban, Budi County

“A girl who starts menstruating is not allowed to milk cows. She can only be allowed to milk a cow she chooses. A ritual called ‘Gogor’ is performed, and she only has to take milk from the cow she milks. If she takes milk from other cows, those cows will die.” Married man, 25+, rural payam, Bor County

Study findings show that the description of menstrual blood as dirty or bad contributes to girls’ perception of menstruation as shameful. It was noted that girls shy away from interacting with others when having their periods.

“Because it’s something very bad, like ‘now your daughter has menses it’s not good to know it.’ It’s something very bad.” Married man, 25+, rural payam, Yambio County

“When they get to hear of how they think of it, they start to shy away, thinking that menstruating is shameful.” Female key influencer, urban payam, Wau County

SOCIAL NORMS ON MENSTRUAL HYGIENE AND MANAGEMENT

Study findings show that it is appropriate for young, menstruating girls to stay in private places. In Yambio, this is done to protect the girl from her brothers, who harshly treat her, thinking that she has lost her virginity; this means that she cannot attract a high bride price that they could have used to pay bride wealth to their own in-laws. The respondents also noted that staying in private spaces protects the brothers and other men in the home from stepping on menstrual blood, which can result in erectile dysfunction, body weakness, and paralysis. Among hunting communities in Yambio, it is perceived that a girl could menstruate for the rest of her life if a hunter steps on her menstrual blood. Further, it was said that hunters use herbs to charm girls when they learn that the girls are menstruating.

“The girls have to hide for two reasons. One, to protect their brothers and men; when a boy or man steps on the menstrual blood, his erection is affected. And two, if a hunter sees a woman

who is menstruating, they have some herbs they use on their bodies, which makes girls more attracted to the hunters; the worst is that if a hunter steps on the blood you will menstruate the rest of your life.” Married woman, 25+, rural payam, Yambio County

“When a girl is in her menses, she is usually kept indoors, only the mother, elder sister, or auntie is allowed to know; if her brothers come to know about this, the brothers usually beat her, in view that she has started sleeping with men.” Married man, 25+, rural payam, Yambio County

“The girls also do not tell their fathers that they are menstruating. The fathers may think that when a girl starts her menses, then she has lost her virginity and usually they beat her up while asking her who broke her virginity.” Married woman, 25+, rural payam, Yambio County

“When a woman gets menses for the first time, it shows that she has lost her virginity and has started moving out with men. The woman would be beaten up and forced to tell who could have broken her virginity.” local chief, rural payam, Yambio County

During the validation workshop, it was noted that these beliefs regarding menstruation are becoming rare with increasing knowledge and awareness about menses. However, they also noted that there remains a strong belief that virginity is believed to attract a better bride price. If brothers think that onset of menses means their sisters are no longer virgin, then this threatens the amount of the bride price.

Participants’ narratives reveal that it is typical of girls to treat menstruation as a private matter. An unmarried young woman in Leer observed that girls, particularly those who are 15 or younger, keep the matter private since older girls mock and label them as prostitutes. Participants reported that menstrual management practices, such as bathing or changing sanitary pads, are to be done in private, unseen by others (e.g., toilets, bathrooms).

“Girls experiencing menses for the first time before the age of 15 are mocked by their older friends, and labeled as prostitutes. They believe that they have started going out with men.” Unmarried woman, less than 25 years, urban payam, Leer County

“She should look for a hidden place where people cannot see her, and clean herself.” Unmarried man, less than 25 years, rural payam, Wau County

“She should go to bathroom, because it (menstrual management) is something which is not good for all people to see; it won’t be good.” Unmarried man, less than 25 years, urban payam, Bor County

Study findings show that it is inappropriate for men to be told about, talk about, and/or support young girls who are menstruating. Participants across study sites reported that only mothers and adult women are responsible for ensuring that young girls effectively manage their menses. In schools, female teachers support mothers in this role. Adult female participants from Yambio observed that women who are informed about the start of the girl’s menses keep it a secret from other family members.

“Men do not have to talk about menstruation; this is because it is the women who handle such issues, only women have to know that their daughter is menstruating.” Married woman, 25+, rural payam, Leer County

“Once she gets her periods, the first person to ask is a mother or older women; they have to keep it a secret from the rest of the family members.” Married woman, 25+, urban payam, Yambio County

“You are still a young girl, and if this is your first time to start seeing your menses, you have to tell your mother. She will have to tell the mother that there is something that she has seen on her body, which she has never seen before.” Unmarried woman, less than 25 years, urban payam, Wau County

SEXUAL DEBUT

Discussions with young people reveal factors that contribute to early sexual debut. They explained that this is done to show affection towards the partner; some observed that often, adolescents equate sex with love. Some unmarried young people discussed that boys coerce girls into having sex, at times asking their peers to convince the partner. Further, some adolescents engage in sex to maintain their relationship and/or prepare themselves for marriage.

“They will decide to have sex; they think that is the meaning of love.” Unmarried woman, less than 25 years, urban payam, Leer County

“If she does not want to have sex, he will talk to one of her friends so that they convince her.” Unmarried man, less than 25 years, urban payam, Bor County

“She will have sex with him so as to maintain their relationship; their friends may think they are planning to marry and establish a family” Unmarried woman, less than 25 years, rural payam, Leer County

NORMS ON SEXUAL DEBUT

Study findings show that it is thought to be appropriate for young people to start having sex in marriage. Respondents reiterated that sex before marriage is prohibited. When parents learn their daughter is sexually active, they marry off their daughter to the man with whom she is having sex.

“It is a total abomination for one to have sex when they are not yet married.” Female key influencer, rural payam, Wau County

“It is not acceptable to have sex before marriage in our community. They should be blamed and punished for having sex before marriage.” Married woman, 25+, urban payam, Leer County

The findings also show that it is typical for men to initiate sex or a discussion about sex with their unmarried partner. Discussions with interviewees revealed that it is a taboo for a woman to initiate or

talk about sex, and those who do so are labeled as sex workers. Several participants cautioned that discussions about sex can only be initiated if the two plan to marry each other.

“In our culture, it is men that can initiate anything about sex. It’s taboo for a lady or woman to ask a man for sex. Even your wife can not ask for sex when you are with her, unless you talk to her about it.” Married woman, 25+, rural payam, Bor County

“Yeah, it’s okay to talk about having sex if their aim of having sex is to get married. It is always done when people love each other.” Married man, 25+, rural payam, Bor County

Interviews with some younger men showed that peers reacted differently when they found out that a male colleague had sex. Some are happy but several others are not, given that one has gone against the community tradition of only having sex in marriage. The latter were of the view that such young people are to be punished.

“Well, some will be happy and others will not, because he would have broken the Dinka tradition of not having sex before marriage.” Unmarried man, less than 25 years, urban payam, Bor County

GENDER-BASED VIOLENCE IN THE CONTEXT OF FAMILY PLANNING ACCESS AND USE

Study findings show that it is thought to be appropriate to physically assault, threaten, verbally abuse, and divorce women who use modern contraceptives without the consent of their spouses.

It was reported that such women are labeled promiscuous and/or witches. Some local chiefs, mainly in rural payams, noted that they punish women who use contraceptives, and the FP providers who offer services without male consent. Several married men encouraged other men with spouses who use contraceptives to marry another woman.

“Going for family planning services without informing the husband is compared to being a witch in the community. This disappoints the husbands, family members, neighbors, and the entire community.” Female key influencer, rural payam, Budi County

“Producing children is God’s plan and if the mother of this woman had decided to take contraceptives, the woman herself would have not been produced, so I am obliged to punish that woman... usually six months of labor at my home, and also the service provider provides 3 months of labor at my home.” Local chief, rural payam, Yambio County

Results show that women have limited autonomy around FP; it is typical of men to make the RH decisions. Some married men and influencers noted that such decisions are collective in nature, given that they have implications for the family and community, especially for family and clan continuity. A few married women stated that women have to be consulted when making such decisions, but these women still tend to reinforce the communal norms that give men the privilege to make reproductive decisions related to childbearing.

“A man, being the head of the family, he must be responsible, take care of the family, and should make good decisions that benefit the family. For anything that happens, whether good or bad, he is responsible. Even the Bible shows a man as the head of the family, and his decisions must be respected.” Married man, 25+, rural payam, Budi County

“Community members have an upper hand in making decisions on contraceptive use, because the woman and all the children she produces belong to the community.” Male key influencer, urban payam, Bor County

“People look at it as something a woman discussed with her man, but this also involves him asking for the opinion of the family. Remember, what they are talking about is about expanding the clan; the family has to know why the woman is no longer interested in producing children.” Local chief, rural payam, Yambio County

Several FP providers reiterated that reproductive health choices are controlled by men. They emphasized the importance of male consent to use modern contraceptives. They noted that contraceptive counseling sessions include finding out if the partner is aware of and agrees to contraceptive use. Some providers ask women to bring their partners. In some facilities in Bor and Leer, there is an unwritten rule that FP services are provided in the presence of the male spouse. A health worker in Yambio explained that the word “family,” drawn from the term “family planning,” denotes working with both men and women.

“I ask because this medicine is called family planning. Family planning, it has a word in there called family, so we are dealing with family and you cannot just give it like that, you must involve the man.” Female FP provider, urban payam, Yambio County

“I will tell her that we cannot give contraception to her if she comes alone to the health facility, unless she comes with her husband.” Female FP provider, rural payam, Leer County

“When young women come to the clinic, my peers can first ask them if they informed their husbands. If yes, then they will be tasked to come with their husband, and from there we can help them in their (the husband’s) presence.” Male FP provider, rural payam, Leer County

The most frequently cited reason for requiring male consent is to prevent violence toward the provider if the male discovers that the woman is secretly using contraception. Several providers cited instances where they had been physically assaulted, verbally abused, or threatened. Some, mainly in rural payams, had been sued in local/traditional courts. Community members observed that the local court can arrest or fine the service provider for providing FP without the consent of the husband.

“If the husband discovers that his wife is taking contraceptives, he can sue both the wife and the doctor in local court; (the doctor can) be arrested because they are stopping the wife from producing more children for the family... they can also be fined with very many cows.” Married man, 25+, rural payam, Leer County

“They often say *should I hear anyone or a health provider giving contraceptives to my wife or to my child, I will come and blow off the head*. So, that is why we don’t just give them (contraceptives) out.” Male FP provider, urban payam, Wau County

“Men are the ones who scare us, the service providers, from giving their wives contraception, because if you do so, the husband might come to harm you. We have encountered such problems several times. When they come they ask you, *Who told you to give contraceptives to my wife? I married her with my own money.* When we encounter such dangerous experiences, we change the approach.” Female FP provider, rural payam, Yambio County

“Two years ago, a midwife gave contraceptives to a woman. One day her husband found the card in her purse. The man fought with her and he came to that midwife saying, *You are the one supporting my wife to do prostitution.* The midwife was charged 20,000 South Sudanese pounds.” Male FP provider, rural payam, Wau County

Interviews with female FP providers in Yambio and Bor revealed that the fear of harm can lead to a health provider neglecting or ignoring what she/he knows professionally, and setting aside his/her professional values. Several providers noted that this presents ethical dilemmas to FP providers’ decision-making on provision of contraceptive services.

“A woman comes, she has 15 children, and indeed you see that she is at a high risk of a maternal death. Indeed, your professional knowledge demands that you provide the service; however, what if something happens to her, what will be the reaction of the husband? Therefore, it is important that the two of them agree.” Female FP provider, urban payam, Yambio County

“We call them medical dilemmas; this is where the client needs the services, but providing it might cause more harm to her and the service provider. You end up deciding that one should not access this service, and in the end, our work ethics are compromised.” Female FP provider, urban payam, Bor County

HEALTH SEEKING FOR FAMILY PLANNING

Assessment findings show that, in urban payams, some women are able to exercise their agency to negotiate access to FP services without consent of their husbands. A few providers explained that this is the right thing to do, given that the burden of care often lies with women. Some participants explained that the effect of unplanned pregnancies on the body is experienced by a woman, and therefore, she holds the ultimate decision-making responsibility.

“Women are the ones who understand their bodies and know what is happening to them. The husbands do not know what happens in a woman’s body.” Male FP provider, urban payam, Yambio

“You know..., you talk to this man a number of times but he never allows you to do so; you are left with no choice but to use them [modern contraceptives].” Married woman, 25+, urban payam, Wau County

“At times, it’s too much for us women. We decide that we need a break, whether he agrees or not. If he does not agree, then he leaves me with no choice but to use it without his consent.” Married woman, 25+, urban payam, Budi County

“We are always told that we should give birth to children. This is easy to say, but for those of us who have gone through it, we know what it means. It reaches a point when you cannot take it anymore, and you have to use them [modern contraceptives] whether he likes it or not.”

Married woman, 25+, urban payam, Leer County

Discussions with married women and female FP providers indicated that it is appropriate for parents and/or caretakers to consent to adolescents’ use of modern contraceptives. Several FP providers require parental consent before provision of contraceptive services to unmarried youth, particularly girls. Female providers noted that there have been instances of backlash and retaliation following the discovery of a child using contraceptives. One of the male respondents called for the imprisonment of health workers who provide contraceptives to young, female adolescents.

“If you give me some letter that is signed by your father or your mother, then I can provide you with contraceptives.” Female FP provider, rural payam, Yambio County

“I feared the parents; the parents are hostile, and so I counseled her and asked that I talk to her parents.” Female FP provider, urban payam, Budi County

Several FP providers were reluctant to provide contraceptive services, particularly to young, unmarried girls. Some providers identified contraceptive use as hazardous, arguing that it lowers one’s ability to conceive. Several health workers cited backlash and retaliation from the family and community as reasons for their hesitancy. Further, a few had perception that this results in engaging in transactional sex.

“For those who are under the age of 16, we always tell them that they are still too young to have contraceptives, so they need to not play around.” Female FP provider, rural payam, Leer County

“So, the policy is, a child is a child, anyone below 18 is still a child, therefore we are not supposed to provide them with contraceptives.” Male FP provider, urban payam, Wau County

“We cannot give (contraceptives) to those below age 16, because they are young.” Male FP provider, urban payam, Yambio County

“I will advise her [a minor] not to use contraception because it is dangerous. It may affect her in the future; she may not be able to give birth if she starts using them at an early age.” Female FP provider, rural payam, Wau County

“No, they are not given to unmarried girls but to boys only.... They [girls] will be perceived as prostitutes.” Married woman, 25+, urban payam, Leer County

Women in Yambio observed that contraceptive use triggers male insecurities. It was noted that a majority of men believe that women who use contraceptives engage in extramarital affairs. It was argued that the decision against use is at times not about childbearing, but rather preventing the possibility of having sex outside marriage. Some providers in Yambio noted that men believe that male providers are having sexual relations with their spouses.

“You know, contraceptive use makes men feel insecure. The husband feels that the woman will now start going out with other men. So, the men are against contraceptive use because they want to prevent their women from going out with other men, there is nothing else.”

Married woman, 25+, rural payam, Yambio County

“We work in quite challenging areas; when you provide pills or implants or any other contraceptive to the woman, some men might think that we are having sex with their wives.”

Male FP provider, urban payam, Yambio County

A few married men in urban payams noted that married women who secure male approval can use modern contraceptives. They argued that males come to this conclusion only when they are convinced that it is for the benefit of the family.

“The woman is not supposed to do anything at home without the man’s consent. If he finally agrees, then she can right away run to get the contraceptive method.” Married man, 25+, urban payam, Wau County

“The man knows what is good for him and his family; if he says yes, then it is okay, he would have thought about it and realized it is a good decision.” Married man, 25+, urban payam, Bor County

Some women reported that their partners encourage them to use contraceptives. For instance, one of the married women in Budi noted that such men are cognizant of the importance of being able to meet the well-being needs of the children. She added that having healthy children improves the man’s social status in the community. This reflects the positive values and perception related to healthy children and child welfare.

“Some men in this community have supported their wives to use contraceptives because it helps them to space and have fewer children; a family can educate and look after them well. When a family looks good, they praise the man, and one of the things that make a family look good is spacing children, as it avoids malnutrition among children. So, for the man to be praised, he asks the woman to use contraceptives.” Married woman, 25+, urban payam, Budi County

Interviews with respondents also showed that some FP providers exercise their agency to encourage uptake of modern contraceptives among students. The health workers reasoned that children at different stages of puberty are sexually active or intend to initiate sexual relations, and therefore need contraceptives to avoid unwanted pregnancies. For this category of adolescents, some providers argued that contraceptive use is important for continuity and completion of school.

“But for girls that want to pursue education, the ones who are not married, we can tell her to use.” Female FP provider, urban payam, Wau County

“According to her age, I need to counsel her to see if she can abstain, but if she cannot and insists, then I can help her.” Female FP provider, urban payam, Wau County

“These girls in the school... they are not married but we know they are tempted to have a boyfriend and then sex. We provide them with contraceptives so that they are able to go on

with their education; we don't want them to get pregnant and drop out of school." Male FP provider, rural payam, Budi County

Some community members observed that contraceptives should be used if one starts to have sex.

"If they have started having sex, it could be good for them to get the contraception, but if they are not playing sex, there is no need to go for it." Married man, 25+, urban payam, Wau County

"I agree with what she is doing because she will still have children, she just wants to space them. She needs a break." Female key influencer, urban payam, Budi County

"Ok, so at this point it needs serious follow up, because if she met a boy or a man by default, she will get pregnant, and this is the time to use contraceptives, so that she can protect herself if she knows that she doesn't want to conceive." Married woman, 25+, rural payam, Wau County

The study findings show that several female adolescents use contraceptives in secrecy. Participants noted that often it is teachers and peers that support the girl's decision to use contraceptives. One female participant described such persons of influence as "civilized," meaning that they use their knowledge and agency to support reproductive health choices of girls.

"Taking contraception is also their [girls'] secret; if the neighbors and the mother knows that she is taking contraception, they will say it's a big mistake." Married man, less than 25 years, urban payam, Wau County

"If they're civilized people, they will support her decision, because she wants to protect herself and her future." Married woman, less than 25 years, urban payam, Yambio County

Discussions with young, married minors and women show that society's disapproval of modern contraceptive use compels them to engage in private interactions with FP providers. The participants reported that at times, services are sought in the home of the health worker to maintain privacy. A few service providers in Wau reported a preference for such interactions, since they are able to protect their clients' identity, thereby avoiding backlash or pushback from the girls' family or male spouses. Some FP providers, particularly in Wau and Bor, observed that several women and girls have only the option of secretly receiving contraceptive services. Some women and girls seek the services only when other patients have left the health facility.

"When they go to the health facility, they make an appointment with the health worker to meet at his/her home. They fear discussing contraceptive use at the health facility. The health workers also prefer private discussions for fear of being prosecuted in case anything goes wrong. The health workers also fear being attacked by the family of the girl when they realize that their daughter is taking contraceptives." Female FP service provider, urban payam, Wau County

"Only those who come to the center while hiding, to access the services, are the ones who are benefiting from the services." Male FP service provider, urban payam, Bor County

“They come when the regular outpatients have left the hospital. We give ourselves time and we speak to them; they do not want their identities disclosed to other people seeking services in the hospital.” Female FP provider, urban payam, Bor County

DISCUSSION

FAMILY PLANNING/REPRODUCTIVE HEALTH

The assessment identifies restrictive and supportive social norms related to FP/RH. Findings suggest that norms shape the dominant social practices (Ortner 1984; Cislighi & Shakya 2018) surrounding modern contraceptive use. The social norms articulated by study respondents are imbued with various community values (Perrucci & Perrucci 2014) related to family honor, male privilege, fertility, and collectivism, among others. Regarding supportive norms, school completion, delayed marriage, and child spacing to promote child health are some of the reported underlying supportive values.

Social norms present expected behavior patterns (Edberg & Krieger 2020) on FP choice and decision-making. Some patterns observed in this assessment reflect entrenched, dominant gender roles. For example, seeking male consent to use modern contraceptives is linked to the male decision-making responsibility. The behavior patterns also reflect the power differentials within society between men and women. Women’s limited autonomy on FP and marriage hinges on unequal power relations. The implication is that adherence to a particular norm goes beyond the fear of sanction to a compliance with the existing gender system.

Social norms also guide communities’ interpretation of programs. They provide expectations around FP/RH that may largely contravene RH rights of women and adolescent girls. Communities organize arguments for or against programs that are perceived to be at variance with the expectations provided by their social norms. For example, as seen in Mkandawire et al. (2019), it is reiterated that FP is a foreign concept meant to destroy the local culture and population.

Social norms may define the limits within which women can use modern contraceptives. Often, this is when they secure consent from the man and their family. Inclusion of the family engenders the decision-making process as a practice or aspect of collectivism—the suppression of the self in the interest of the community (Bukuluki 2013). Decisions on modern contraceptive use are placed in a bigger framework of clan and family continuity, and on replacement of men and women lost through war (Mkandawire et al. 2019). This further shrinks the space within which women can make decisions on their reproductive health as they interact with other structures that uphold the patriarchal system (e.g., local chiefs).

The assessment revealed social norms and related sanctions that render it acceptable to engage in GBV to enforce adherence to nonuse of modern contraception. The expectation that various sanctions are to be enacted following transgressions of particular norms, such as those related to discouraging use of FP, normalizes women’s experience of various forms of violence and coercion. This also presents perpetrators with a “right” to inflict various forms of GBV on women and adolescent girls. This builds social relationships characterized by women’s and girls’ victimization. It also involves the

victimization of those providing FP services to women and girls without the consent of men and parents.

The sanctions against use by women and girls and the provision of FP has resulted in private practices primarily focused on health care-seeking for FP services. It is common for women and girls to seek services in secrecy; for some, this is within the homes of the FP providers. Some seek services after other community members conclude their health facility visits. Although this reflects agency for the women and providers, it increases risk for GBV if husbands, parents, or communities find out. This highlights the need for integrated programming for RH and GBV that promotes use of FP, but at the same time addresses risks of GBV.

The assessment revealed that some sections of the community are conscious or aware of the benefits of modern contraceptive use, such as preventing unwanted pregnancies and lengthening subsequent birth intervals. As a result, some women, adolescent girls, and FP providers can exercise their agency through negotiations/interactions with their partners/husbands/parents to participate in the decisions that impact their lives. However, this often reinforces women and girls' subordination and gender roles, especially if a decision comes against the use of modern contraceptives. A form of agency can also be seen through resistance to behavioral expectations and subversion, as women and girls seek services secretly. Such forms of agency, however, have not achieved community-wide change on modern contraceptive use. Notably, women's agency has been constrained by structural factors, including the limited availability of FP services. Such factors further limit their capacity to mobilize against restrictive norms.

In the states of Wau, Yambio, and Budi, community respondents reported supportive behavioral expectations of child spacing through abstinence. This norm is embedded in community values and aspirations on child well-being. With about 41 percent of marriages being polygamous (South Sudan Household Survey 2012; Stern 2015), it is likely that it is women who must abstain. This might have unintended outcomes, such as male spouses marrying other wives, or engaging in multiple and concurrent partnerships.

Additionally, in some cases there is a disconnect between South Sudan policies related to FP and actual practice. Although policies allow for contraceptive use by all women of reproductive age (15+), regardless of marital status, and with no reference to male partner concurrence, there are providers who are not comfortable providing FP to women without their husbands' approval. This may be related to the provider's own beliefs (social norms), but may also be related to the real or perceived risk the provider faces if she/he does provide contraceptives to a woman without receiving concurrence from her husband. This same tension may occur if a provider recommends or distributes contraceptives to unmarried adolescent girls.

HEALTH SEEKING

Women and young people's intention to use modern contraceptives is embedded in social norms on decision-making in a household. The social norms place the decision-making responsibility with a man and his family. As earlier indicated, this engenders reproductive health decisions as an aspect of collectivism.

Given that FP providers are part of the community social network and are bound by restrictive social norms, they are required to collect proof of male or parental consent from potential users of modern contraceptives. Some providers may try to exercise agency by not ensuring agreement from a client's partner or parent. Findings suggest, however, that this is discouraged locally by threats or punishment. FP providers are thus very cautious to provide FP services to women and girls without the additional, norms-driven consent.

This context has shaped the FP/RH health care-seeking environment and has implications for patient-provider communication. Under these constraints, it is difficult for women and FP providers to initiate and have meaningful, comprehensive conversations on family planning and contraception.

Structural factors also affect access and use of FP/RH services. Study findings suggest that the concentration of services in urban locations, the thin FP services infrastructure, and an unreliable supply of modern contraceptives (Devkota et al. 2021) contribute to the unmet need for FP across the various sites.

That notwithstanding, the study identified progressive attitudes and practices among sections of the community that could facilitate health seeking for FP services. For example, some FP providers recognize the importance of women and girls being in control of their bodies, and the uncoerced decision-making on their reproductive health.

MENSTRUAL HYGIENE MANAGEMENT

MHM is an important issue for all study participants. A range of materials are used in MHM, including rags, cotton, animal skins, leaves, ash, and cow dung. Some of these materials and practices can be considered positive assets for MHM, but some may expose girls and women to infection, depending on the context and level of hygiene. The materials for MHM are sourced both close by, at home or nearby bushes, and out-of-home, such as riverside/streams, schools, health facilities, shops, and markets. Mothers and peers are the primary source of information on management of menses. The elders, health care providers, and female teachers support mothers in this role.

Social and gender norms define appropriate behaviors for girls during their menses, including dietary intake and expected interactions in given social spaces and activities (e.g., preparing and serving food). The norms also define the identity of girls who have started menstruating as mature, ready for marriage, and adults. In some communities, especially in Wau and Yambio, the onset of the first period is celebrated. Additionally, traditional rituals related to first menses are performed at all study sites. Although the initial menses might be celebrated, ongoing menses are identified as smelly or dirty by some sections of the community.

Some positive norms, attitudes, and beliefs support girls in MHM, including being fed body-building foods, being cared for by mothers, and the perception that menstruation is a natural and normal phenomenon.

SEXUAL DEBUT/EARLY MARRIAGE

Across study sites, there is a shared expectation that sex before marriage is prohibited. Arranged marriages are common and acceptable, and parents take the lead in negotiations for marriage of their sons and daughters. There are socioeconomic connotations that are associated with marriages; in the study communities, daughters are perceived as sources of wealth, especially via cows and money. The high community expectations on bride price have consequences for females, as girls/women are expected to be virgins. Use of contraceptives, if known, will lower the bride price, as well as put the bride at risk of GBV.

Positive or alternative norms, beliefs, attitudes, and practices are beginning to emerge in some sections of communities and can challenge community norms related to early/child marriage. In some families, children (age 17 and younger) are recognized as not ready for marriage. For other parents, readiness for marriage is associated with the completion of secondary school. Some women in the communities have demonstrated agency by supporting their daughters' decisions to complete school and delay marriage.

GENDER-BASED VIOLENCE

The findings suggest that GBV, in the context of RH, includes reproductive coercion, controlling behaviors, physical violence, forced/early marriages, and psychological violence. Notably, the main types of GBV, physical and psychological violence, constitute part of the social sanctions prescribed by the social norms that provide limited autonomy and decision-making for women and girls on RH. Women's and girls' (and FP providers) sensitivity to the physical and psychological abuse compels them to follow the restrictive social norms.

It is important to note that certain types of GBV fit into social norms. For example, it is appropriate under these norms for women and girls to be physically assaulted when they use modern contraceptives.

KEY INFLUENCERS

A range of key influencers on the decisions to use modern contraceptives, sexual debut, health-seeking behavior (in relation to FP), and MHM were identified. For MHM, the key influencers include mothers, siblings, peers, female teachers, women leaders, elders, and religious leaders. For sexual debut and marriage, the main influencers include parents, traditional authorities, religious leaders, women leaders, health care providers, and peers. For contraception and health seeking, the key influencers include elders, traditional chiefs, religious leaders, mothers-in-law, women leaders, FP providers, and peers. In relation to FP-related GBV, traditional chiefs were identified as key influencers, especially in handling family disputes and mediation. The attitudes, beliefs, practices, and social norms of key influencers reflect the dominant community attitudes, beliefs, practices, and social norms, and key influencers reinforce existing community social and gender norms.

RECOMMENDATIONS

The following recommendations are provided in two sections: overall recommendations, which apply broadly to SBC and gender activities moving forward, and the SBC design and programming messaging-specific recommendations, which provide more detail and nuance across audiences and geographical areas.

It is suggested that as each county undertakes participatory workshops to develop county-specific, strategic SBC action plans, the recommendations are unpacked with relevant stakeholders at the payam and boma levels who will help to co-design and assist in the implementation and monitoring of SBC and gender activities.

OVERALL RECOMMENDATIONS

- a) Increase women's and girls' agency to initiate conversations with health providers regarding their health, including self-care. This will promote more meaningful interactions between women and girls in need of FP and provider support and counseling. This includes discussions around provision of FP services for girls in school. It is also an opportunity to develop gateway moments, or opportunities to integrate other counseling that may be linked to other health practices, e.g., early and frequent antenatal visits when pregnant, exclusive breastfeeding, and early childhood development.
- b) Strengthen the capacity of health providers to provide adolescent-friendly SRH services, particularly contraception services, and to establish adolescent- and youth-friendly corners or spaces to increase discussions about and access to SRH information and FP services.
- c) Plan for the inclusion of health providers, among other key stakeholders, as partners in SBC activities and social norms transformation through capacity strengthening and involvement in co-creation workshops for SBC activities.
- d) Unpack the meaning of "family planning" among key audiences to determine what would be a meaningful value proposition that could be more acceptable. For example, in Ghana, for FP/RH/ and maternal, newborn, and child health (MNCH), formative work and co-creation with Ghanaian communities led to the value proposition, "Good Life, Live it Well."¹⁷ This resonated for years and has been incorporated within SBC activities for over a decade. Messages should emphasize the family benefits, positive values, and perceptions related to children and child well-being that resonate with communities.
- e) Build on positive norms, especially those related to child spacing, and the values related to healthy children and child welfare, as assets for promoting FP. In doing so, it is important to reflect on the implication of these practices on the well-being and rights of women. Prior reflection will help to avoid harmful, unintended outcomes, to focus on the "do-no-harm" principles, and to promote gender equality and equity.
- f) Given the GBV risks associated with women and girls seeking FP services in secrecy, combine programming for promoting uptake of FP with interventions geared toward prevention and

¹⁷ https://www.facebook.com/gdlifeghana/about/?ref=page_internal.

response to GBV. Integrated programming for FP promotion and GBV prevention should therefore become a key priority in both SBC activities and provision of services.

- g) To foster normative change, provide key influencers with comprehensive FP/RH information and relevant tools to engage target audiences. Key influencers also should be engaged in SBC activities and social norms transformation as change agents/advocates. Key influencers also include the engagement of high-level officials (state/county level) in understanding FP and RH policies, as currently they are not being fully practiced as laid out in the policies. Communities should also be provided with information through CHWs and other community peer groups to increase their knowledge of their rights throughout their life stages.
- h) Given the male domination in FP/RH decision-making, emphasize innovative male engagement strategies that can harness men/boys as partners in advocating for and promoting the use of SRH services, including modern contraceptives, and address age of marriage, bride price, importance of girls' and boys' education, the role men have in contraceptive choices, and related traditions.
- i) Recognize key urban and rural differences (e.g., low knowledge of contraception in rural areas, shifting positive norms in urban areas), and align SBC activities accordingly.
- j) Understand the dynamics specific to South Sudan that influence community norms (e.g., contraception is preventing the growth of clans and tribes).

SPECIFIC RECOMMENDATIONS: SOCIAL AND BEHAVIOR CHANGE DESIGN, PROGRAMMING, MESSAGING

- a) Create or promote positive norms, beliefs, attitudes, and practices for voluntary FP uptake, and use these through community dialogues. It is important to carefully study the values that embody restrictive norms so that the positive norms being promoted are in line with these values, especially if they promote gender equality. The Community Action Cycle, developed by the Institute of Reproductive Health and Save the Children, is a suitable approach to adapt, given the populations that this approach targeted are very similar to the populations in South Sudan (especially in terms of migration patterns and proximity¹⁸). Within this approach, utilize key influencers, including elders, traditional chiefs, religious leaders, mothers-in-laws, women leaders, and peers.
- b) Create space for dialogue among all audiences to clarify misconceptions underlying the social norms (e.g., when a girl has her first menses, she should not play sports or go to school, that women who use FP are prostitutes, or that FP causes infertility) and emphasize the benefits of adopting the positive norms.
- c) Explore behavioral diagnosis/behavioral economics¹⁹ with support from Breakthrough ACTION staff to create solutions for health provider dialogues around “medical dilemmas.” Through this,

¹⁸ For more information on the Community Action Cycle (2013), see: https://irh.org/wp-content/uploads/2013/10/Community_Action_Cycle_Implementation_Guide_FINAL.pdf.

¹⁹ <https://breakthroughactionandresearch.org/designing-for-provider-behavior-change-developing-solutions-to-provider-side-barriers-to-quality-care/>.

providers and managers can identify feasible solutions to provide appropriate services to clients without compromising work ethics and other evidence-based guidelines (e.g., not providing services due to fears related to husband/partner/parent consent). These could include “safe spaces,” private and confidential services to remove stigma around seeking contraceptive services, or “wellness days” for men and adolescents, which have proved to be effective in improving uptake of integrated services, including FP counseling in Zambia.²⁰

- d) SBC activities should unpack respected community values and gender norms, such as child well-being, maternal health, the importance of healthy children, and healthy fertility across targeted audiences. This will allow the participants to discuss the negative social norms that affect attainment of these values and aspirations, and co-create feasible and doable solutions within their households and communities.
- e) Catalyze and reinforce new positive behaviors and norms by creating rewards for early adopters (e.g., creating a social support system for couples who have agreed and started using FP, or for community resource persons promoting FP). Work with local governments and key influencers to enact and implement positive by-laws and ordinances that are context specific. This can be linked to MIHR’s social accountability approach, Partnership Defined Quality, so that these behaviors/norms cross-fertilize the process.
- f) Address misinformation and misconceptions by providing comprehensive information about FP to providers, key influencers, and targeted users of the FP services. This should be complemented by capacity strengthening in clinical FP counseling about the side effects of FP and their management, the positive benefits of FP, and improved provider behavior, especially promoting prevailing attitudes that influence positive client-provider dialogue.
- g) Given the key role that local and traditional courts play in adjudication and mediation of GBV cases, including FP-related GBV, strengthen their capacity in integrating human rights and reproductive health rights into their ongoing on-the-job training. If this type of mechanism does not exist, work with these groups to advocate for its inclusion. This can support sensitization around the importance of a healthy life through routine service provision across health areas by qualified, trusted, and trained health providers. It will also gradually explore, based on MIHR lessons learned and Breakthrough ACTION’s piloting, the entry points for discussion around FP among these providers.
- h) Consider the relationships between individual, community, and societal levels (socio-ecological model) to facilitate agency of individuals, especially women, girls, providers, groups, and communities, to explore and maintain positive/alternative norms, particularly around misconceptions. This includes multiple touch points (e.g., community dialogue, community radio, social media, client-provider interaction, and men’s/women’s groups.)
- i) Ensure audience segmentation within MIHR project areas. This will allow the delivery of tailored programs and messages during project implementation (e.g., county/payam-level co-creation of SBC activities) in collaboration with Breakthrough ACTION and other key implementing partners.

²⁰ https://breakthroughactionandresearch.org/wp-content/uploads/2020/09/BR_Zam_IntSBC_IntHlth_ProgBrief.pdf.

- j) Incorporate the findings in collaboration with Breakthrough ACTION's innovation teams to integrate SBC messages into information sessions for mothers at health facilities and in community outreach. Identify influential women leaders to organize mother's groups (including mothers-in-law when appropriate) to facilitate a series of dialogues prioritized by the mothers. These can include MHM, sexual debut and marriage, and FP care seeking, among others.
- k) Focus on activities that ensure mothers/adult women are responsible for ensuring that young girls effectively manage menses, and provide comprehensive information on MHM to the mothers and adult women as key influencers. Where extant, use information sessions that mothers and elderly women provide when a girl has her first menses as an entry point to discuss other RH/FP issues (Leer), or at celebrations and rituals performed during first menses (Leer/Bor). Information sessions may also be an opportunity to discuss feasible options for girls to continue their education during menses (e.g., routine, remote learning from teachers) in collaboration with other implementing partners focused on girl's education. This may be particularly relevant through women's social and economic empowerment groups, such as village savings and loans associations.

BIBLIOGRAPHY

Ali, N.M. 2011. "Gender and State Building in South Sudan." Washington, DC: United States Institute of Peace. Available at:

https://www.peacewomen.org/assets/file/SecurityCouncilMonitor/Missions/SouthSudan/special_report_usip_december_2011.pdf.

Azjen, I. 1991. "The Theory of Planned Behavior." *Organizational Behavior and Human Decision Processes*, 50, 79–211.

Baschieri, A., J. Cleland, S. Floyd, A. Dube, A. Msona, A. Molesworth, J.R. Glynn, and N. French. 2013. "Reproductive Preferences and Contraceptive Use: A Comparison of Monogamous and Polygamous Couples in Northern Malawi." *Journal of Biosocial Science*, 45(2):145–166. DOI:

<https://doi.org/10.1017/S0021932012000569>.

Bukuluki, P. 2013. "When I steal, it is for the benefit of me and you": Is Collectivism Engendering Corruption in Uganda?" *International Letters of Social and Humanistic Sciences*, 5, 27–44.

CARE USA. 2017. *Applying Theory to Practice: CARE's Journey Piloting Social Norms Measures for Gender Programming*. Washington, DC: Cooperative for Assistance and Relief Everywhere, Inc. (CARE).

Casey, S.E., S.K. Chynoweth, N. Cornier, M.C. Gallagher, and E.E. Wheeler. 2015. "Progress and Gaps in Reproductive Health Services in Three Humanitarian Settings: Mixed-Methods Case Studies." *Conflict and Health* 9, no. Suppl 1, Taking Stock of Reproductive Health in Humanitarian: S3.

Central Intelligence Agency (CIA). 2020. *The World Fact Book: South Sudan*. Washington, DC: CIA. Available at:

<https://www.cia.gov/library/publications/the-world-fact-book/geos/od.html>.

Cislaghi, B., and H. Shakya. 2018. "Social Norms and Adolescents' Sexual Health: An introduction for Practitioners Working in Low and Mid-income African countries." *African Journal of Reproductive Health*, 22(1):38–46.

Department of Health, Education and Welfare. 1979. *The Belmont Report—Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Devkota, B., R. Anguyo, C. Jeffery, J.J. Valadez. 2021. *Republic of South Sudan National Household Health Survey 2020*. Liverpool: LATH South Sudan and the Liverpool School of Tropical Medicine.

Edberg, M. and L. Krieger. 2020. "Recontextualizing the Social Norms Construct as Applied to Health Promotion." *Population Health*, 10:100560.

Elmusharaf, K., E. Byrne, and D. O'Donovan. 2017. "Social and Traditional Practices and Their Implications for Family Planning: A Participatory Ethnographic Study in Renk, South Sudan." *Reproductive Health*, 14(1):10.

Garcia-Moreno, C., H. Jansen, M. Ellsberg, L. Heise, C.H. Watts, et al. 2005. *The WHO Multi-country Study on Women's Health and Domestic Violence*. Geneva, Switzerland: World Health Organization.

Gardsbane, D. and A. Atem. 2019. *USAID/South Sudan Gender-Based Violence Prevention and Response Roadmap*. Washington, DC: Banyan Global.

Global Women's Institute (GWI) and the International Rescue Committee (IRC). 2017. *No Safe Place: A Lifetime of Violence for Conflict-affected Women and Girls in South Sudan. Main Results Report*. Washington, DC and London: The George Washington University and the International Rescue Committee, pp. 6, 28.

Institute for Reproductive Health (IRH). 2020. *Social Norms Exploration Tool*. Washington, DC: Institute for Reproductive Health, Georgetown University.

Japan International Cooperation Agency (JICA). 2017. "Country Gender Profile Republic of South Sudan Final Report." Available at: https://www.jica.go.jp/english/our_work/thematic_issues/gender/background/c8h0vm0000anjqj6-att/south_sudan_2017.pdf.

Kane, S., M. Rial, A. Matere, M. Dieleman, E.W.J. Broerse, and M. Kok. 2016. "Gender Relations and Women's Reproductive Health in South Sudan." *Global Health Action* 9: 33047. Available at: <http://dx.doi.org/10.3402/gha.v9.33047>.

Learning Collaborative to Advance Normative Change (LC). 2020. Institute for Reproductive Health. *Learning Collaborative Essential Resources*. Available at: <http://irh.org/resource-library/learning-collaborative-essential-resources>.

Mackie, G., F. Moneti, H. Shakya, and E. Denny, E. 2015. *What Are Social Norms? How Are They Measured?* New York, NY: UNICEF, p. 11. Available at: https://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf.

Madut, K.K. 2020. "Determinants of Early Marriage and Construction of Gender Roles in South Sudan." *Journal of Black Studies* April–June: 1–9.

Mandal, M., and L. M. Albert. 2020. *Reproductive Empowerment Scale: Psychometric Validation in Nigeria*. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Available at: <https://www.measureevaluation.org/resources/publications/tr-20-393>.

Maxwell, L., K. Devries, D. Zions, J.L. Alhusen, and J. Campbell. 2015. "Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis." *PLoS ONE*, 10(2): e0118234.

McLarnon-Silk, C., E. Spindler, and F. Quirke. 2017. [What's family planning got to do with intimate partner violence? Exchanging with experts at the 2017 SVRI Forum](#). Institute for Reproductive Health Blog.

Mkandawire, P., K. MacPherson, K. Madut, O.D. Atari, A. Rishworth, and I. Luginaah. 2019. "Men's Perceptions of Women's Reproductive Health in South Sudan." *Health and Place*, 58, 4.

- Ministry of Health South Sudan (MOH) and National Bureau of Statistics (NBS). 2010. *South Sudan Household Survey 2010 Final Report*. Juba, South Sudan: Ministry of Health.
- Ortner, S. 1984. "Theory in Anthropology since the Sixties." *Comparative Studies in Society and History*, 26, 126–166.
- Palmer, J.J., and K.T. Storeng. 2016. "Building the Nation's Body: The Contested Role of Abortion and Family Planning in Post-War South Sudan." *Social Science & Medicine*, 168: 84–92.
- Perrucci, R., and C.C. Perrucci. 2014. "The Good Society: Core Social Values, Social Norms, and Public Policy." *Sociological Forum*, Vol. 29, No. 1, pp. 245–258.
- Silverman, J.G., and A. Raj. 2014. "Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control." *PLoS Med*, 11(9): e1001723.
- Slymaker, E., R.H. Scott, M.J. Palmer, L. Palla, M. Marston, L. Gonsalves, and K. Wellings. 2020. "Trends in Sexual Activity and Demand for and Use of Modern Contraceptive Methods in 74 Countries: a Retrospective Analysis of Nationally Representative Surveys." *The Lancet Global Health*, 8(4), E567–E579.
- Stern, O. 2015. "This is how marriage happens sometimes: women and Marriage in South Sudan." In: Bubenzer, F., O. Stern, (Eds.), *Hope, Pain and Patience: the Lives of Women in South Sudan* (1–12). Cape Town, South Africa: Fanele.
- Sulayman, S.S. Jammeh, C. Y, Liu, S.-F. Cheng, and J. Lee-Hsieh. 2014. "Community-Based Study on Married Couples' Family Planning Knowledge, Attitude, and Practice in Rural and Urban Gambia." *African Health Science* 14(2): 273–280. DOI: 10.4314/ahs.v14i2.1.
- Tancioco, V., P. Jeffery, M. Shin-Sim, and A. Sridhar. 2016. "Cultural Influences on Family Planning Use: A Mixed-Methods Pilot Study in South Sudan." *Obstetrics & Gynecology* 127: 125S.
- Track 20. 2019. *Project Trends in mCPR, South Sudan*. http://www.track20.org/South_Sudan.
- United Nations Development Programme. 2018. "Gender Inequality Index, Table 5." *Human Development Reports*. <http://hdr.undp.org/en/composite/GII>.
- Ibid. 2020. *United Nations Human Development Reports, South Sudan*. <http://hdr.undp.org/en/countries/profiles/SSD>.
- United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). 2019. *UNOCHA: South Sudan. Humanitarian Country Team. Humanitarian Response Plan Monitoring Report: January 2019*. DOI: 10.4314/ahs.v14i2.1 March.
- United States Institute of Peace. 2011. "Dowry and Division: Youth and State Building in South Sudan." Washington, DC: United States Institute of Peace. Available at https://www.files.ethz.ch/isn/134640/SR_295.pdf.
- USAID South Sudan. 2019. *USAID. Food Assistance Fact Sheet, South Sudan, April 9, 2019*.

Ibid. 2020. *USAID South Sudan – Crisis, Fact Sheet #4, Fiscal Year 2020, February 10, 2020.*
[https://reliefweb.int/report/south-sudan/south-sudan-crisis-fact-sheet-4-fiscal-year-fy-2020.](https://reliefweb.int/report/south-sudan/south-sudan-crisis-fact-sheet-4-fiscal-year-fy-2020)

WHO. 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women.* Geneva, Switzerland: Department of Gender and Women's Health, Family and Community Health, World Health Organization.

Ibid. 2018. *Guidance on Ethical Considerations in Planning and Reviewing Research Studies on Sexual and Reproductive Health in Adolescents.* Geneva, Switzerland: World Health Organization.

World Bank. 2019. “Maternal mortality ratio (modeled estimate, per 100,000 live births).” WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 2000 to 2017. Geneva, Switzerland: World Health Organization. Available at: [https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS.](https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS)

APPENDIX ONE: DATA COLLECTION TOOLS

(Note: as archival documents, these tools are presented in their original formats)

Key Informant Interviews with Stakeholders

Key Informant Interview		Interviewer:
Name/ID#:	Date:	Notes:
Location:	Organization:	
Title:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
Obtain informed consent and provide study introduction (insert)		
Illustrative questions for stakeholders		
<p>After sharing the IDIs with the stakeholders for review, ask the following questions:</p> <ul style="list-style-type: none"> • How relevant to the South Sudan context are the behaviors and social norms presented? • What other attitudes and behaviors are important to consider for a study trying to identify underlying social norms related to FP use in SS? • How can we better capture other health related areas among the vignettes, for example, menstrual hygiene management, fertility awareness and intentions, health seeking for FP/RH & MNCH care, health-seeking priorities (e.g., children vs. women/adults), GBV and related risk factors – defined by respondents, and support and services for GBV? • Is there information in any of the stories that may not be appropriate to say? If so, how can it be modified to be more culturally acceptable? • What FP services, campaigns, etc. are available or operating in each site? • What is important as selection criteria for study participants? • How should study participants be recruited to ensure a diverse but representative sample? 		

In-Depth Interview (IDI) with married and unmarried adults

In-Depth Interview			Interviewer:
Name/ID#:	Age:	Date:	Sub-group (tick): <ul style="list-style-type: none"> <input type="checkbox"/> Young women (ages 15-24), unmarried <input type="checkbox"/> Young men (ages 15-24), unmarried <input type="checkbox"/> Young women (ages 15-24), married <input type="checkbox"/> Young men (ages 15-24), married <input type="checkbox"/> Older Women (ages 25-49), unmarried <input type="checkbox"/> Older Men (ages 25-49), unmarried <input type="checkbox"/> Older Women (ages 25-49), married <input type="checkbox"/> Older Men (ages 25-49), married
What age married?	What age first child? How many children?		
Location:	Ethnicity/Tribe:		
Highest level of Education: <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Primary: <input type="checkbox"/> Some <input type="checkbox"/> Completed <input type="checkbox"/> Secondary: <input type="checkbox"/> Some <input type="checkbox"/> Completed <input type="checkbox"/> Post-Secondary: <input type="checkbox"/> Some <input type="checkbox"/> Completed 			
Where were you born?			Have you moved because of the conflict? <input type="checkbox"/> yes <input type="checkbox"/> no
Obtain informed consent and provide study introduction (insert)			
Illustrative Vignettes			
Vignette 1 option, <u>younger adults</u> (this is illustrative; the vignette will be adapted locally): Mary is a 16-year-old student who lives with her parents and grandparents. She attends school and helps her mother with household chores. One day Rose, Mary's cousin, comes over to visit Mary's family. They are almost the same age. Rose lets Mary's family and Mary know that she is engaged and getting married in a month's time to Joe, who she met near her village. She also strongly suggests to Mary that she should also marry soon as she is getting old for marriage. Rose reveals that she also knows someone from their village who is interested in marrying Mary.			

- What would most adolescent girls in Mary position do in this situation? (descriptive norms)
- What would Rose and most other girls expect Mary to do in this situation? (injunctive norms)

But Mary doesn't want to marry young or start to have children. She announces that she does not want to marry at this age. Rose worries about additional time that she may take off because of the possibility of getting pregnant. She is also concerned about taking time off during her monthly menstruation but doesn't really share this information with her soon to be husband or friends because she is afraid of what they may say about things that happen during her monthly menstruation.

- What would Rose and most other girls say about Mary's decision? (Sanctions)
- Would the opinions and reactions of her peers make Mary change her mind about refusing the marriage? (Sensitivity to sanctions)
- Are there any circumstances where it would be considered more or less acceptable for Mary not to get married at her age? (Exceptions)

Vignette 2 option, younger adults (this is illustrative; the vignette will be adapted locally):

Mary, age 18, and Jacob, age 20, had a traditional arranged marriage. Mary agreed to get married but she was intent on continuing her education and wanted to delay having a first child for 2 years while she finished her training as a nursing assistant. Both she and Jacob felt pressure from their parents, their elders, their friends and others but Jacob agreed to go along with her plan.

- What would other couples like Mary and Jacob in the community do if Mary continues to use injections to delay having a first child? (descriptive norms)
- What would people in the community expect Mary and Jacob to do if Mary continues to use injections to delay having a first child? (injunctive norms)
- What are the possible bad/negative things that could happen to Mary and Jacob (in their family, in the community) if Mary continues to use contraception to prevent pregnancy? (sanctions)
 - Would Mary and Jacob change their mind about contraception if bad/negative things happened? (sensitivity to sanctions)
 - What are some of the things that could happen for Mary and Jacob if Mary continues to use contraception to prevent pregnancy? (exceptions)

Vignette 3 option, older adults (this is illustrative; the vignette will be adapted locally):

Rose had her first child when she was 18. After a second child at age 20 she decided she didn't want to have more children for a few years. Her husband, however, insisted that a large family was important. After talking with her friends, she went to a clinic and began getting injections without her husband knowing. But when she did not get pregnant her husband became suspicious and threatened to beat her if she did not become pregnant soon.

- What would other women like Rose do in this situation? (descriptive norms)

- What does Rose think her friends expect her to do in this situation? (injunctive norms)
 - What do you think other people in the community will say about Rose if she continues to use injections to space her pregnancy? (sanctions)
 - Would the opinions and reactions of people in her community make Rose change her mind about using injections to space her pregnancy? (sensitivity to sanctions)
- Are there any circumstances where it would be considered more or less acceptable for Rose to stop injections to space her pregnancy? (Exceptions)

RH Health Care provider communication (Probe “why” after each question)

For each statement, please state if you “strongly agree”, “agree”, “disagree”, “strongly disagree”, or “does not apply” if you have not visited your health care provider regarding contraception.

1. Rose and her health care provider talk about using contraception.
2. Rose can initiate conversations about using contraception with her health care providers.
3. Rose can ask her health care provider questions about using contraception.
4. Rose can share her opinions about using contraception with her health care providers.
5. When discussing contraception with her health care provider, s/he pays attention to what Rose has to say.

In-Depth Interview (IDI) with health providers

In-Depth Interview		Interviewer:
Name/ID#:	Age:	Date:
Married? <input type="checkbox"/> yes <input type="checkbox"/> no What age married?	What age first child? How many children?	
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Cadre: <input type="checkbox"/> CHW <input type="checkbox"/> Midwife <input type="checkbox"/> Nurse <input type="checkbox"/> Doctor	
Location:	Ethnicity/Tribe:	
Where were you born?		Have you moved because of the conflict? <input type="checkbox"/> yes <input type="checkbox"/> no
Obtain informed consent and provide study introduction (insert)		
Illustrative Vignettes		
Initial questions: <ol style="list-style-type: none"> 1) What types of family planning services do you offer your clients? 2) What type of counseling do you use when discussing these family planning services? 3) What do you see as challenges in discussing family planning methods with your clients? 		
Vignette 1 – younger men and women (15-24) (this is illustrative; the vignette will be adapted locally): Let us say a young girl has come to see you. She came by herself and says she is 18 years old. She tells you that she has a boyfriend and would like to prevent pregnancy because she is still in school. She has never used family planning before and has questions about how it will affect her menstruation and side effects of any of the methods. <ul style="list-style-type: none"> ● What would you want to know about this young girl to help her? ● What would you tell her about contraception and which method you think would be best for 		

her given her concerns?

- What do your peers tell young women with these questions in this situation?
- What do you think your peers should tell young women with these questions in this situation?

Vignette 2 – older men and women (25-49) (this is illustrative; the vignette will be adapted locally):

Now let's say a woman has come to see you who is also alone, and says she is 28 years old. The woman tells you that she is married and lives with her husband. She just had her second child one year ago and would not like to have another child so soon. She has never used family planning before and has talked to her friends about methods they have used but is not sure about what is best for her.

- What would you want to know about this young girl to help her?
- What would you tell her about contraception and which method you think would be best for her given her concerns?
 - What do your peers tell young women with these questions in this situation?
 - What do you think your peers should tell young women with these questions in this situation?

RH Health Care provider communication (Probe "why" after each question)

For each statement, please state if you "strongly agree", "agree", "disagree" or "strongly disagree".

1. You talk about using contraception with your clients.
2. Your clients can initiate conversations about using contraception with you.
3. Your clients feel they can ask you questions about using contraception.
4. Clients can share their opinions about using contraception with you as a health provider.
5. When discussing contraception with your client, you pay close attention to what they have to say.

In-Depth Interviews (IDIS) with Influencer reference groups

In-Depth Interview			Interviewer:
Name/ID#:	Age:	Date:	Additional notes:
Reference Group type (specify):			
<input type="checkbox"/> Religious leader: _____ <input type="checkbox"/> Community leader: _____ <input type="checkbox"/> Elder: _____ <input type="checkbox"/> Other: _____			
Location:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity/Tribe:	
Highest level of Education:			
<input type="checkbox"/> None <input type="checkbox"/> Primary: <input type="checkbox"/> Some <input type="checkbox"/> Completed <input type="checkbox"/> Secondary: <input type="checkbox"/> Some <input type="checkbox"/> Completed <input type="checkbox"/> Post-Secondary: <input type="checkbox"/> Some <input type="checkbox"/> Completed			
Where were you born?			Have you moved because of the conflict?
			<input type="checkbox"/> yes <input type="checkbox"/> no
Obtain informed consent and provide study introduction (insert)			
Illustrative Vignettes			
<p>Vignette 1 option, <u>younger adults</u> (this is illustrative; the vignette will be adapted locally):</p> <p>Mary is a 16-year-old student who lives with her parents and grandparents. She attends school and helps her mother with household chores. One day Rose, Mary’s cousin, comes over to visit Mary’s family. They are almost the same age. Rose lets Mary’s family and Mary know that she is engaged and getting married in a month’s time to Joe, who she met near her village. She also strongly suggests to Mary that she should also marry soon as she is getting old for marriage. Rose reveals that she also knows someone from their village who is interested in marrying Mary.</p> <ul style="list-style-type: none"> • What would most adolescent girls in Mary position do in this situation? (descriptive norms) • What would Rose and most other girls expect Mary to do in this situation? (injunctive norms) <p>But Mary doesn’t want to marry young or start to have children. She announces that she does not want to marry at this age. Rose worries about additional time that she may take off because of the possibility of getting pregnant. She is also concerned about taking time off during her monthly menstruation but doesn’t really share this information with her soon to be husband or friends</p>			

because she is afraid of what they may say about things that happen during her monthly menstruation.

- What would Rose and most other girls say about Mary's decision? (Sanctions)
- Would the opinions and reactions of her peers make Mary change her mind about refusing the marriage? (Sensitivity to sanctions)
- Are there any circumstances where it would be considered more or less acceptable for Mary not to get married at her age? (Exceptions)

Vignette 2 option, younger adults (this is illustrative; the vignette will be adapted locally):

Mary, age 18, and Jacob, age 20, had a traditional arranged marriage. Mary agreed to get married but she was intent on continuing her education and wanted to delay having a first child for 2 years while she finished her training as a nursing assistant. Both she and Jacob felt pressure from their parents, their elders, their friends and others but Jacob agreed to go along with her plan.

- What would other couples like Mary and Jacob in the community do if Mary continues to use injections to delay having a first child? (descriptive norms)
- What would people in the community expect Mary and Jacob to do if Mary continues to use injections to delay having a first child? (injunctive norms)
- What are the possible bad/negative things that could happen to Mary and Jacob (in their family, in the community) if Mary continues to use contraception to prevent pregnancy? (sanctions)
 - Would Mary and Jacob change their mind about contraception if bad/negative things happened? (sensitivity to sanctions)
 - What are some of the things that could happen for Mary and Jacob if Mary continues to use contraception to prevent pregnancy? (exceptions)

Vignette 3 option, older adults (this is illustrative; the vignette will be adapted locally):

Rose had her first child when she was 18. After a second child at age 20 she decided she didn't want to have more children for a few years. Her husband, however, insisted that a large family was important. After talking with her friends, she went to a clinic and began getting injections without her husband knowing. But when she did not get pregnant her husband became suspicious and threatened to beat her if she did not become pregnant soon.

- What would other women like Rose do in this situation? (descriptive norms)
- What does Rose think her friends expect her to do in this situation? (injunctive norms)
 - What do you think other people in the community will say about Rose if she continues to use injections to space her pregnancy? (sanctions)
 - Would the opinions and reactions of people in her community make Rose change her mind about using injections to space her pregnancy? (sensitivity to sanctions)

Are there any circumstances where it would be considered more or less acceptable for Rose to stop injections to space her pregnancy? (Exceptions)

APPENDIX TWO: CONSENT/ASSENT FORMS

(Note: as archival documents, these forms are presented in their original formats)

INFORMED CONSENT FORM

Thank you for taking the time to meet with me and the rest of the team today. My name is [name of interviewer]. We are working with the USAID-funded MOMENTUM Integrated Health Resilience project. We are interested in learning how people in South Sudan think about and/or make decisions related to family planning and reproductive health.

We are talking to people in five different states in South Sudan. In each place we are talking married and unmarried people from ages 15 to 49; religious leaders, traditional leaders, elders, health care providers, and others who may be in a role to advise or influence the thinking of people about family health. We will be asking you questions about family planning, reproductive health, gender-based violence, and how you make decisions to seek health care.

Purpose

Results from the study will be used to improve the way people learn about family planning and reproductive health in South Sudan, and to learn what you think about gender-based violence, so we can work towards preventing it. To keep your families healthy, we also want to better understand how families make decisions about seeking health care, so we can better design programs to keep South Sudanese families healthy.

Study Procedures

Today, we have a few questions for you and then would like to listen to stories on this tablet [hold up and point to tablet]. I'll show you how to use this tablet and record your answers on the tablet. This should take 30-45 minutes for you to give us your opinion about the stories on this tablet.

Confidentiality

Information you provide us is private, and we will not share your name with anyone. Information you provide will be combined with information we learn from others too and will be compiled into a report. Although, we may quote you in the report, we will not identify you by name or any other information that may lead to your identification.

Voluntary Participation

Your participation in this study is voluntary. If you don't want to be part of the study, it is OK. Or, if you agree, but then change your mind, you can just tell me, and we can stop the interview. You can also just answer the questions you want to and not answer other questions. If you don't participate, stop the interview, or choose not to answer any questions there will not be any negative effects for you.

Possible Risks

It is possible that some of the questions may make you feel uncomfortable. Although we really want to know what you think, you do not need to answer any questions that you do not want to. If you do feel upset, and would like services related to any of the topics discussed, we can provide a referral to a service provider not far from your community.

Benefits of the Study

We hope you enjoy talking with us about your thoughts. We also hope the results of this study will be used to improve the well-being of families in this community. Your participation will also help strengthen programs in South Sudan, such as MOMENTUM Integrated Health Resilience, to better meet the health needs of South Sudanese.

Compensation

You will receive [name compensation provider (e.g., hygiene kit)] for your participation in this study, as a token of appreciation for your time and contribution. Participation in this study is solely voluntary; however, we appreciate your participation in this study, and thank you for your time.

Questions about the study

Before you say **yes or no** to participating, we will answer any questions you have. You can also ask me questions later too. Do you have any questions now? [Pause & answer all questions]

Your Rights

If you have any questions later about the study, you may contact one of the study investigators:

Contact Name and phone number

If you are willing to participate, please sign this consent form, and we can begin.

Informed Assent Form

Thank you for taking the time to meet with me and the rest of the team today. My name is *[name of interviewer]*. We are working with the USAID-funded MOMENTUM Integrated Health Resilience project. We are interested in learning how people in South Sudan think about and/or make decisions related to family planning and reproductive health.

We are talking to people in five different states in South Sudan. In each place we are talking married and unmarried people from ages 15 to 49; religious leaders, traditional leaders, elders, health care providers, and others who may be in a role to advise or influence the thinking of people about family health. We will be asking you questions about family planning, reproductive health, gender-based violence, and how you make decisions to seek health care.

If you are 15-17 years old, and not married, we need to get consent from your parent or guardian, as well as your consent. Is your parent here? If so, we can explain the study to both of you, as we will need consent from both of you.

Purpose

Results from the study will be used to improve the way people learn about family planning and reproductive health in South Sudan. To keep your families healthy, we also want to better understand how families make decisions about seeking health care, so we can better design programs to keep South Sudanese families healthy.

Study Procedures

Today, we have a few questions for you and then would like to listen to stories on this tablet *[hold up and point to tablet]*. I'll show you how to use this tablet and record your answers on the tablet. This should take 30-45 minutes for you to give us your opinion about the stories on this tablet.

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Information you provide us is private, and we will not share your name with anyone. Information you provide will be combined with information we learn from others too and will be compiled into a report. Although, we may quote you in the report, we will not identify you by name or any other information that may lead to your identification.

Voluntary Participation

Your participation in this study is voluntary. If you do not want to be part of the study, it is OK. Or, if you agree, but then change your mind, you can just tell me, and we can stop the interview. You can also just answer the questions you want to and not answer other questions. If you don't participate, stop the interview or choose not to answer any questions there will not be any negative effects for you.

Possible Risks

It is possible that some of the questions may make you feel uncomfortable. Although we really want to know what you think, you do not need to answer any questions that you do not want to.

If you do feel upset, and would like services related to any of the topics discussed, we can provide a referral to a service provider not far from your community.

Benefits of the Study

We hope you enjoy talking with us about your thoughts. We also hope the results of this study will be used to improve the well-being of families in this community. Your participation will also help strengthen programs in South Sudan, such as MOMENTUM Integrated Health Resilience, to better meet the health needs of South Sudanese.

Compensation

You will receive [name compensation provider (e.g., hygiene kit)] for your participation in this study, as a token of appreciation for your time and contribution. Participation in this study is solely voluntary; however, we appreciate your participation in this study, and thank you for your time.

Questions about the study

Before you say **yes or no** to participating, we will answer any questions you have. You can also ask me questions later too. Do you have any questions now? [Pause & answer all questions]

Your Rights

If you have any questions later about the study, you may contact one of the study investigators:

Contact Name and phone number

If you are willing to participate, please sign this consent form, and we can begin.

APPENDIX THREE: PARTICIPANT CHARACTERISTICS

Table 7 (Appendix). Highest Educational Attainment: Community Members and Key Influencers

Formal Education Status	Frequency	Percentage
None	76	32.48
Primary–Some	70	29.91
Secondary–Some	30	12.82
Post-Secondary–Completed	30	12.82
Secondary–Completed	19	8.12
Primary–Completed	6	2.56
Post-Secondary–Some	3	1.28
Total	234	100

Table 8 (Appendix). Cadre of FP Providers

Provider Cadre	Frequency	Percentage
Nurse	15	46.88
Midwife	9	28.12
CHW	4	12.5
Doctor	4	12.5
Total	32	100