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Citation for published version:
Palmer, J & Storeng, KT 2016, 'Building the nation's body: The contested role of abortion and family planning in post-war South Sudan', *Social Science & Medicine*, vol. 168, pp. 84–92. https://doi.org/10.1016/j.socscimed.2016.09.011

Digital Object Identifier (DOI):
10.1016/j.socscimed.2016.09.011

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Peer reviewed version

Published In:
Social Science & Medicine

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Download date: 23. Jul. 2021

Accepted Manuscript

Building the nation's body: The contested role of abortion and family planning in post-war south Sudan

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PII: S0277-9536(16)30510-X

DOI: 10.1016/j.socscimed.2016.09.011

Reference: SSM 10836

To appear in: *Social Science & Medicine*

Received Date: 31 March 2016

Revised Date: 8 September 2016

Accepted Date: 9 September 2016

Please cite this article as: Palmer, J.J., Storeng, K.T., Building the nation's body: The contested role of abortion and family planning in post-war south Sudan, *Social Science & Medicine* (2016), doi: 10.1016/j.socscimed.2016.09.011.

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Social Science & Medicine manuscript number: SSM-D-16-00947R1

Article title: Building the nation's body: the contested role of abortion and family planning in post-war South Sudan

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Acknowledgements: We would like to thank the study informants, International Medical Corps for facilitating access to the Protection of Civilian camp and particularly Dr. Festo Jambo Elias at the University of Juba's College of Medicine for facilitating introductions to informants and participating in several discussions about emerging findings. We also thank colleagues at LSHTM, Guttmacher Institute, Population Council and the Centre for Cultures of Reproduction, Technologies and Health (CORTH) for useful comments on early presentations of this work.

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1 # Building the nation's body: the contested role of abortion and family

2 planning in post-war South Sudan

3 ## Abstract

4 This paper offers an ethnographic analysis of public health policies and interventions targeting
5 unwanted pregnancy (family planning and abortion) in contemporary South Sudan as part of wider
6 'nation-building' after war, understood as a process of collective identity formation which projects a
7 meaningful future by redefining existing institutions and customs as national characteristics. The
8 paper shows how the expansion of post-conflict family planning and abortion policy and services are
9 particularly poignant sites for the enactment of reproductive identity negotiation, policing and
10 conflict. In addition to customary norms, these processes are shaped by two powerful institutions -
11 ethnic movements and global humanitarian actors - who tend to take opposing stances on
12 reproductive health. Drawing on document review, observations of the media and policy
13 environment and interviews conducted with 54 key informants between 2013 and 2015, the paper
14 shows that during the civil war, the Sudan People's Liberation Army and Movement mobilised
15 customary pro-natalist ideals for military gain by entreating women to amplify reproduction to
16 replace those lost to war and rejecting family planning and abortion. International donors and the
17 Ministry of Health have re-conceptualised such services as among other modern developments
18 denied by war. The tensions between these competing discourses have given rise to a range of
19 societal responses, including disagreements that erupt in legal battles, heated debate and even
20 violence towards women and health workers. In United Nations camps established recently as parts
21 of South Sudan have returned to war, social groups exert a form of reproductive surveillance,
22 policing reproductive health practices and contributing to intra-communal violence when
23 clandestine use of contraception or abortion is discovered. In a context where modern

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24 contraceptives and abortion services are largely unfamiliar, conflict around South Sudan's nation-

25 building project is partially manifest through tensions and violence in the domain of reproduction.

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26 # Introduction

27 War unquestionably harms people's health and health infrastructures. Maternal mortality, one of
28 the most important indicators of the performance of health systems, for example, is elevated during
29 armed conflict (UNFPA, 2015). War can also accelerate social change capable of sustaining, fostering
30 or subverting national, cultural and gender identities (Grabksa, 2014; Hammond, 2004). Such
31 extreme circumstances put cultural systems at risk of seismic change, and reveal the implicit
32 assumptions and contradictions underlying previously unquestioned power relations (Ginsburg &
33 Rapp, 1995). In moments of crisis, the ways people struggle to deliver and access healthcare can be
34 interpreted as projections of their disparate views of the nation they are struggling to construct
35 (Baines, 2003; DiMoia, 2013; Wick, 2008). In this paper, we analyse public health policies and
36 interventions targeting unwanted pregnancy (family planning and abortion) in contemporary South
37 Sudan as part of wider 'nation-building' after war. We understand national-building as a process of
38 collective identity formation which projects a meaningful future by redefining existing institutions
39 and customs as national characteristics (von Bogdandy et al., 2005).

40 Reproduction, in particular, provides a terrain for imagining new cultural futures. Children are born
41 into complex social arrangements through which legacies of property, positions, rights and values
42 are negotiated over time. When mothering is viewed as women's primary social role, women are not
43 only biological reproducers but also key cultural 'transmitters' (Yuval-Davis, 2003). Reproduction is
44 therefore "inextricably bound up in the (re)production of culture" (Ginsburg & Rapp, 1995, 2) and
45 integral to identity formation when cultural ideals are at the core of conflicts, as in South Sudan.

46 So as to assert this identity politically, groups in conflict tend to suppress heterogeneity to speak of
47 their hardship in a homogeneous voice and to represent the true 'essence' of their culture (Yuval-
48 Davis, 2003). In ethnic-based conflicts, it is common for gender identities to become hardened
49 (Erten, 2015; Malkki, 1995; Shiffman et al., 2002) or essentialised (Grabksa, 2014). Women are
50 transformed into boundary-makers in upholding ethnic purity, reified as the reproducers of the

51 ethnic group and therefore in need of protection (Yuval-Davis, 2003). Masculinities become
52 militarised, with men enjoined to kill enemy men and defile enemy women to deliberately disrupt
53 the ethnic purity and cultural continuity of the other group (Einhorn, 2006). Armed movements from
54 Serbia, Rwanda, Burundi, Japan, Palestine, and Turkey to South Sudan have therefore called for
55 women to bear babies 'for the nation' (Einhorn, 2006; Erten, 2015; Malkki, 1995; Shiffman et al.,
56 2002).

57 While war exaggerates femininities and masculinities, plenty of women and men resist enacting such
58 singular visions of their bodies (Baines, 2003). War can also empower and emancipate people.
59 Displacement over international borders can liberalise gender relations through encounters with
60 global humanitarianism or host communities, as it did for South Sudanese in Kenya and Uganda
61 (Edward, 2007; Grabksa, 2014), Burundians in Tanzania (Malkki, 1995) and Afghans in Iran (Piran,
62 2004). After conflicts, however, many nations seek to reassert cultural norms to impose the ethnic
63 ideals for which a war was fought (Abramowitz & Moran, 2012; Einhorn, 2006; Mclean-Hilker, 2014).
64 Repatriation of displaced populations therefore often involves a difficult period of reconciling
65 cultural differences (Grabksa, 2014; Hammond, 2004). Returnee women, in particular, are often
66 perceived as agents of social transformation that threaten established gender relations (Grabksa,
67 2014).

68 Those seeking to uphold patriarchal norms of 'the nation' during and after war thus often monitor or
69 police women's behaviour – through the legal systems, public shaming, violence and threats of
70 violence – to ensure that they enact their allotted roles (Baines, 2003; Einhorn, 2006). 'Reproductive
71 control' (Moore et al., 2010) or 'reproductive coercion' (Miller & Silverman, 2010) – men's attempts
72 to promote pregnancy in their female partners through verbal pressure and threats, contraceptives
73 interference or sabotage, and coercion related to pregnancy continuation or termination – may help
74 explain why intimate partner violence is often associated with reduced contraceptive uptake and
75 abortion (Adjiwanou & N'Bouke, 2015; Coyle et al., 2015). Women's access to economic power and

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76 cultural ideologies about what they can achieve also influence women's own willingness to limit
77 their births (Browner, 2000). Women's susceptibility to reproductive coercion and the gendered
78 meanings they assign to their reproductive behaviours are thus highly dependent on the local
79 politics of reproduction (Browner, 2000; Ginsburg & Rapp, 1995).

80 International organisations and foreign governments, in contrast, commonly see the end of war as
81 an opportunity for bold interventions that mark a break from a nation's chaotic past (Cometto et al.,
82 2010; Percival et al., 2014, 1). Seemingly technical projects like funding health programmes and
83 formulating health policy serve the ambitious goal of promoting state legitimacy and peace-building
84 through the delivery of strong health services (Kruk et al., 2010; von Bogdandy et al., 2005). Public
85 hospitals thus become overtly political spaces, the sites of presidential ribbon-cutting ceremonies, ,
86 protests, and even mob justice (Radio Tamazuj, 2015; South Sudan News Agency, 2014).

87 As studies from other post-conflict settings make clear, encounters with fertility control technologies
88 are "not simply an issue of a technological object in isolation but rather an entire cultural package
89 and the sets of values and aspirations associated with it" (DiMoia, 2013, 9; Erten, 2015; McGinn,
90 2000; Shiffman et al., 2002). Family planning, in particular, is proposed as an antidote to war,
91 capable of empowering women to participate in peace talks and reduce fertility to ward off a
92 demographic 'youth bulge' that contributes to future conflicts (Potts et al., 2015). Below, we
93 examine how family planning and abortion become particularly poignant sites for the enactment of
94 reproductive identity negotiation, policing and conflict, configuring reproduction in relation to the
95 idea of the nation, at a time when populations are mixing, institutions reorganising, and identities
96 shifting.

97 Specifically, we describe conflicting discourses about control of women's reproduction promulgated
98 by customary institutions, the Sudan People's Liberation Army/Movement (SPLA/M) and
99 international donors with the Ministry of Health (MoH). Following Macleod et al (2011), we
100 understand discourses as coherent systems of meanings that support institutions, are located in

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101 history, and produce power relations and ideological effects. We also acknowledge that people do
102 not develop oppositional positions independent of categories in the dominant culture (Ginsburg &
103 Rapp, 1995). While customary institutions in South Sudan uphold marriage traditions that promote
104 many children and post-partum abstinence, the SPLA mobilise pro-natalist ideals and reject post-
105 partum abstinence and modern family planning technologies for military gain and for nation-building
106 after the war. Meanwhile, international donors and domestic technical officers within the Ministry
107 of Health have re-conceptualised control of pregnancy through family planning as a legitimate and
108 modern post-war nation-building project. We analyse how these competing discourses and
109 associated interventions have given rise to a range of societal responses, including tensions that
110 erupt in violence between women, men, and health workers in healthcare institutions. As parts of
111 South Sudan have returned to war (2013-present), these tensions have come to a head in the
112 confined spaces of United Nations (UN) camps where interventions require less negotiation with the
113 government but war still shapes women's power. Here, what we term 'reproductive surveillance'
114 limits women's use of accessible family planning services and leads to intra-communal violence
115 when clandestine abortion is discovered. We conclude that, in a context where modern family
116 planning and abortion services are largely unfamiliar, conflict around nation-building is partially
117 manifest through violence in these domains.

118 Methods

119 Our analysis is based on ethnographic research conducted by JJP between 2013 and 2015, as part of
120 a multi-country study of reproductive health policy change designed and led by KTS. JJP conducted
121 critical review of policy and media documents; monitoring of social media discussions; and
122 observations in the capital, Juba during visits to four reproductive health facilities (public and
123 private), a UN Protection of Civilians camp, and a women's organisation network event on South
124 Sudan's ratification of the 'Maputo' Protocol on the Rights of Women in Africa. At the time of field

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125 work, there were more than 100,000 people living on UN bases, including 33,000 in Juba, nearly all
126 of whom were ethnic Nuer (UNMISS, 2014).

127 JJP also conducted interviews with 54 key informants (in Juba and by phone) from the Ministry of
128 Health, the Ministry of Gender, Child & Social Welfare, the South Sudan Human Rights Commission,
129 the United Nations Population Agency (UNFPA), nurse and medical training colleges, legal
130 organisations, domestic women's organisations, politicians, international and national non-
131 governmental organisations (NGOs), donors, domestic and international universities, health
132 providers, and international and national journalists. Informants likely to be able to speak about
133 reproductive health policy were identified through web-searching, recommendations from the
134 Ministry of Health and Juba University, and snowball sampling. Interviews followed a flexible topic
135 guide to identify major policy debates and events, policy actors and their positions on family
136 planning and abortion. When permitted, interviews were audio-recorded and transcribed.
137 Documents were considered public articulations of policy actors' positions and thematically analysed
138 together with interview transcripts and field notes which included opinions or positions circulated
139 orally, first to identify and describe the construction of major policy discourses as they related to
140 nation-building and second to identify and contextualise instances of policing behaviour
141 (surveillance and sanctioning) which could suggest social tension between the discourses.

142 The research ethics review boards of the Ministry of Health, Republic of South Sudan and the
143 London School of Hygiene & Tropical Medicine approved the study. All informants gave written
144 informed consent. Because family planning and abortion policy is a highly sensitive issue, individuals'
145 statements have been anonymised; all interviews were conducted in private with informants
146 allowed to offer contributions without organisational attribution or being recorded.

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147 ## Customary reproductive norms

148 South Sudanese are encouraged to have families that are as large as possible, including "as many
149 wives as a man can afford" (Pillsbury et al., 2011, 17) and "as many children as God gives" (Aveyard
150 & Apune, 2013, 14). The fertility rate is high, at 7.1 live births per woman (MoH-GoSS, 2013b). Large
151 families not only provide security from high child mortality and care for adults in old age, but also
152 lend social status (Hutchinson, 1996). Through marriage and the exchange of bride wealth, women
153 act as bridge-builders, building alliances with other families, clans and ethnic groups (Onyango &
154 Mott, 2011). New wives are expected to become pregnant quickly, while infertility suggests both
155 economic and spiritual poverty (Perner, 2001). Young girls who become pregnant are encouraged to
156 marry, since children's well-being is the responsibility of men's families. Almost half (45%) of South
157 Sudanese women are married and around a quarter (28%) have delivered a live birth by their 18th
158 birthday (MoH-GoSS & NBS, 2011). Child-spacing through breastfeeding and post-partum abstinence
159 is common (Aveyard & Apune, 2013), facilitated by the couple living apart temporarily and/or men
160 spending time with other women. Modern contraceptives are rarely used. Humanitarian agencies
161 introduced condoms and contraceptive pills on a small scale in 1999 (Pillsbury et al., 2011), but by
162 2010, the modern contraceptive prevalence ratio was only 1.2% (4.0% for all methods (MoH-GoSS &
163 NBS, 2011)), and only a third of women could name a modern method (McGinn et al., 2011).

164 In the absence of contraception, abortion is common. Constitutional law permits abortion to save a
165 mother's life or in the case of intra-uterine foetal death (MoLACD, 2009, sections 216-222). Many of
166 our informants, including a parliamentarian interviewed for this study, believed that "People
167 understand that abortion is legal when the life of the mother is at risk, they welcome this
168 intervention even, provided it is managed by professional health workers". Many others spoke of
169 abortion as illegal, without nuance (see also Onyango and Mott (2011)). Although widely regarded as
170 sinful, induced abortion also happens in all South Sudanese ethnic groups (Perner, 2001). Among the
171 Dinka people, for example, Jok claims that women acceptably justify inducing abortion to other

172 women by mobilizing the concept of a ‘broken back’: a euphemism which acknowledges the
173 reproductive suffering of women who have already had many pregnancies (Jok, 1999a). Among
174 unmarried women, abortions may also be induced in secret if the woman or her family does not
175 wish to pursue a marriage (Perner, 2001).

176 Women mostly self-induce abortions through methods that seek to mimic spontaneous causes, such
177 as ingesting bitter roots or herbs, an overdose of malaria medicines, laundry detergent, battery acid
178 or petrol; inserting objects into the cervix; or ‘playing rough’ (Jok, 1999a; Pillsbury et al., 2011).
179 According to health providers, women in the capital increasingly present for post-abortion care after
180 self-induction or receiving incomplete terminations by providers in the private health sector.
181 Complications from unsafe abortions burden already stretched hospital services (Onyango & Mott,
182 2011). For example, in one tertiary facility, 45% of admissions to the gynaecological unit over a seven
183 year period were for post-abortion care (Onyango & Mott, 2011). Although data is lacking, unsafe
184 abortion undoubtedly contributes to South Sudan’s extremely high maternal mortality, estimated to
185 be between 730 and 2,054 maternal deaths per 100,000 live births (Kassebaum et al., 2014; SSCCSE,
186 2007; WHO, 2014).

187 War & the nation’s reproductive front: militarised discourses on 188 reproduction

189 During and after Southern Sudan’s second civil war against the Khartoum government in the Arab
190 north (1983-2005), armed movements in the non-Arab African South mobilised pro-natalist ideals
191 for military gain and for nation-building, which remain highly influential. Two out of the country’s 12
192 million people are said to have died in this conflict, and the preference for many children gained
193 urgency as people mourned their losses (Pillsbury et al., 2011). While the SPLA originated among a
194 group of Dinka rebels defecting from the Sudan national army, over time it loosely encompassed
195 most rebel groups from other ethnic areas of the country, thereby exposing other tribal groups to its

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196 military culture (Schomerus & Allen, 2010). Today, the SPLA serves as South Sudan's regular army,
197 and its 'political wing', the SPLM, is the country's governing political party, though both have
198 splintered into multiple factions (some ethnic) since 2013.

199 From the late 1980s, the SPLA highlighted women's reproductive capacities as a key contribution to
200 the war effort (Jok, 1999a, b). Soldiers were encouraged to have as many children as possible in case
201 they died in war. The military also promulgated the concept of "brotherhood in procreation" to
202 encourage soldiers to support each other in their quest for progeny, even from other men's wives
203 and even through rape (Jok, 1999b, 440). Women were also urged to "hold up the reproductive
204 front," Jok explained in a radio interview (McNeish, 2013), to contribute to future military power
205 and to the continuity of village life and ethnic identities.

206 By the mid-1990s, Dinka women commonly felt the military's emphasis on reproduction as a
207 national obligation exceeded traditional norms and lent men too much power over sexuality (Jok,
208 1999b). Civilian populations protested when the sexual violence which accompanied military
209 movements crossed ethnic lines, and the SPLA, regarding these protests as a threat to its popular
210 support, responded by publicly executing rapists (Perner, 2001). When soldiers' sexual violence
211 occurred within ethnic communities, however, elites in both military and customary institutions
212 were complacent because they feared allowing women to re-shape sexual norms themselves (Jok,
213 1999b). In a context of young men conditioned to the use of force and precarious access to health
214 and social care for women and their children, induced abortions appeared to become an increasingly
215 common phenomenon: a small survey, contributing one of the only estimates from this time,
216 suggested 35% of women terminated their pregnancies (Jok, 1999a).

217 In the post-war period, militarised expectations of women's fertility were repurposed for Southern
218 nation-building and recovery as the SPLM sought to distinguish itself from the north both culturally
219 and administratively, in preparation for Independence. Around the time of the Comprehensive
220 Peace Agreement in 2005, for example, former rebel leaders in the highest political office set about

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221 dismantling South Sudan's only domestic family planning organisation, according to a
222 parliamentarian interviewee. This was ostensibly done under a nationalist agenda because the
223 organisation survived on international support through Khartoum, but it was clear to observers that
224 it was actually opposition to foreign *ideas* about reproduction that underlay the move. According to
225 this parliamentarian, SPLM officials entreated its staff "not to talk about family planning, [but to]
226 allow people to produce as much as they can". In the lead-up to the Independence referendum in
227 2011, politicians again emphasised strengthening the nation through numbers. 'Come back to be
228 counted' was the slogan of campaigns calling refugees back to re-build and re-populate South Sudan.

229 Being counted was a political act to strengthen political negotiations with Khartoum because census
230 estimates would ultimately determine the South's share of oil wealth, and enabled refugees to
231 demonstrate their citizenship in a nascent state (Hovil, 2010). In the buoyant pre-Independence
232 atmosphere, the SPLM's ideas about building a new nation were popular. Family planning, then, was
233 not only unnecessary, but also unpatriotic. One health provider in Juba put it quite simply: "[i]n
234 South Sudan, the history of this war, many people have died so it sounds as if you are anti-human,
235 not promoting life." Thus, reproduction after the war was most often spoken about as serving the
236 new nation by replacing the high numbers of people who were lost. This was the key discourse that
237 the Ministry of Health and its international partners sought to challenge.

238 Family planning to build a healthy nation: 'modern' discourses on 239 reproduction

240 Given the extremely limited capacity of the new government's Ministry of Health after the war,
241 international institutions, notably the World Bank and the World Health Organization, and
242 international donors working through international NGOs were central drivers of health policy
243 formulation in South Sudan (Cometto et al., 2010). In assisting the Ministry of Health to design
244 foundational health policies and financing mechanisms, their stated priorities were to implement

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245 interventions with the highest evidence-based impact so as to demonstrate health as a 'dividend' of
246 peace and prevent a return to war (ibid). Ministry of Health actors, many of whom had received
247 university training or experience abroad, claimed the adoption of international best practices served
248 to "fast forward" the development of health services (MoH-GoSS, 2007, 1). Early policy documents
249 included a large number of sexual and reproductive health services including family planning and
250 post-abortion care, though not safe abortion services (Roberts et al., 2008). Like in other African
251 countries (Storeng & Ouattara, 2014), offering post-abortion care was a politically palatable way for
252 both domestic and international policy actors to promote the idea that they were providing 'life-
253 saving care' without having to engage in the contentious issue of abortion rights.

254 The international community was highly aware of the SPLA's pro-natalist population replacement
255 discourses. Consequently, many NGOs considered providing contraceptives a political and security
256 risk. One NGO representative even feared that communities who rejected family planning might
257 take-up arms against them and force programmes to close, compromising their wider maternal
258 health and primary healthcare aims. As donors described in interviews, dispelling such fears was
259 thus a key aim when USAID, UK Aid and the Ministry of Health commissioned a series of in-depth
260 qualitative studies on South Sudanese attitudes and practices related to family planning which they
261 hoped NGOs would read before designing interventions (Aveyard & Apune, 2013; Mason, 2012;
262 Pillsbury et al., 2011).

263 As in many parts of Africa, these studies characterised 'family planning' as a customary cultural ideal
264 when practiced as birth spacing through post-partum abstinence, a healthy way of life that many
265 Southern Sudanese communities aspired to return to. More controversially, however, the studies
266 also highlighted the local realities that made these customary practices difficult and justified
267 introducing modern methods of contraception, such as war-related displacement to urban or camp
268 settings with restricted living space forcing husbands and wives to share bedrooms (Aveyard &
269 Apune, 2013; Pillsbury et al., 2011). The studies documented suspicion and stigma associated with

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270 modern contraceptive methods and popular discourse, lumping abortion with other examples of
271 cultural 'pollution' imported by returnees and foreigners after the war, such as short skirts and hip-
272 hop culture (see also Grabksa, 2014). Like elsewhere, people commonly invoke such dichotomies
273 between 'modern' and 'customary'/'traditional' to make sense of competing gender ideologies
274 (Plesset, 2006). Significantly, however, some policy actors claimed that the reports suggested
275 communities' sincere curiosity and openness to learning about modern health practices which could,
276 potentially, extend to contraceptives. Other research supports this interpretation. For instance,
277 Christian church-goers in South Sudan have sometimes been influenced by liberal Western ideas of
278 modernity, including on reproductive health (Grabksa, 2014), and have come to see use of modern
279 health care as an act of religiosity or patriotism: an acknowledgement of the sacrifices of war and
280 part of the nation-building experience (Palmer et al., 2014).

281 The new Ministry of Health's first Family Planning Policy, which built on the commissioned studies,
282 appealed to such patriotism, re-framing militarised pro-natalist discourses by counting loss of
283 reproductive health services among the casualties of war:

284 *South Sudan has been devastated by decades of war in terms of loss of human*
285 *life, massive displacement, destruction of both physical and social infrastructure,*
286 *and loss of human resource development opportunities, including the loss of*
287 *experienced health professionals. This, combined with a lack of awareness, has*
288 *seriously limited both access to and use of quality reproductive health services*
289 *including family planning (FP). As a result the country has some of the highest*
290 *maternal and child mortality rates in Sub-Saharan Africa (MoH-GoSS, 2013a, p.*
291 *1,).*

292 Like the commissioned studies, this policy document subtly sought to reposition attitudes on family
293 planning, as a Ministry of Health representative explained: "We need to change this discourse to
294 replace those lost with *healthy* people so that she [a woman] can look after her children and

295 contribute to the national economy. These are the twists and turns we need people to understand
296 to link health and development."

297 Many health workers, discussing their experience of the country's first family planning programmes,
298 saw the association between family planning, abortion services and modernisation as an inevitable
299 national trajectory. One obstetrician even predicted it would be only a matter of time before family
300 planning and abortion services are as widely available as in neighbouring countries like Ethiopia,
301 Sudan and Kenya: "Sometimes in Kenyatta [hospital in Nairobi] you have to clean 100, even 200
302 pregnancies, so abortion was legalised to minimise these complications. For us, we will be heading
303 to that, as urbanisation becomes a problem" Indeed, since 2013 especially, contraceptive coverage
304 and method availability has expanded to include the internationally standard range of short-
305 (condoms, pills, injections) and long-term (implants, intra-uterine devices) methods, as has access to
306 safer medical abortion medicines (Hudgins et al., 2014).

307 Among the public, however, such ideas around family planning and modernity did not yet resonate.
308 Women's group leaders spoke animatedly about several other reproductive health issues in local
309 political terms: gender-based violence, fistula as a problem of early marriage, and HIV as a problem
310 of widow inheritance, all of which were worse because of war. Discussions in the Maputo Protocol
311 workshop revealed how groups had successfully argued for protection against fistula and for a
312 women's right to divorce by mobilising women's and men's desire to uphold reproductive norms
313 which reward large families. Just as Jok's 'broken back' euphemism simultaneously valorised many
314 pregnancies and permitted a woman to terminate one, a lawyer described the best way to win a
315 divorce was to prove that a woman wanted to contribute children to society but had been
316 abandoned by her husband and therefore was denied her reproductive potential. Divorce would
317 make her a better mother. No women's groups, however, seemed to have developed arguments for
318 or against family planning or abortion. As one representative said, "Women's groups might take up
319 family planning one day, but I don't know..."

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320 ## Contesting competing discourses in post-conflict Juba

321 The tensions between customary, military and donor-influenced policy discourses have given rise to
322 a range of societal responses, including tensions that erupt in legal battles, heated debate and even
323 violence between women, men, and workers in health facilities. For example, while Ministry of
324 Health discourses draw on ideas about liberalising women's rights set out in aspirational
325 constitutional documents, such legal ideas have not widely influenced decisions in customary courts,
326 which remain important because the post-conflict state lacks capacity to extend government courts
327 into rural areas (Deng, 2013). No court rejects contraceptives as inherently illegal. However, while
328 South Sudan's recently developed Bill of Rights states that women have the right to freedom of
329 choice and thus do not need a man's consent to use contraceptives, in customary courts, ultimate
330 authority typically rests with men (Bior, 2013). As one constitutional lawyer explained: "[a]ll the
331 customs in South Sudan for the 64 tribes favour men". Since people in South Sudan "believe in
332 lineage", a man can theoretically argue for and be granted divorce if he reports that his wife has
333 used contraceptives without his permission because this "perverts" the natural way of building
334 families (ibid). Contraception "victimiz[es] him" by artificially limiting the future value of the dowry
335 he has paid for a woman. According to Ministry of Health representatives, some men have
336 successfully sued international organisations that provided contraception to their wives in
337 customary courts.

338 This legal context helps explain the ubiquitous stories family planning providers in Juba tell about
339 their female clients being beaten by men who suspect they have been using contraception in secret.
340 As one such provider described: "In our culture, if a woman does something secretly, he can beat
341 her. […] If the husband refuses and then the lady goes [to get contraception]… It will bring big
342 problems, even if she has 5 or 10 children, he will divorce". Discussions around the choice of
343 contraceptive method are therefore based not only on clinical considerations but also, as several
344 antenatal care providers explained, on how well the method can be concealed, with injections, intra-

345 uterine devices and implants preferred. Relatedly, health workers must also be prepared to risk
346 anger from clients' husbands:

347 *The other day, a man came carrying a gun, demanding the implant to be removed*
348 *from his wife's arm. We tried to talk to him, saying the woman came to us, she*
349 *has a right. But he insisted and threatened us. So we said 'Ok, no problem, we*
350 *don't want to spoil your relationship with your wife. We will remove, and she is*
351 *welcome if she wants to come back another time.' The woman consented, it was*
352 *just not the man.*

353 Health providers also risk sanctions from some local government authorities who oppose family
354 planning. One lawyer told of a health provider who was jailed for giving women contraception "in
355 secret". At her release two days later she was forced to choose between resigning and working
356 under the surveillance of security guards. According to international organisations, medical
357 personnel have chased away women seeking family planning counselling at antenatal clinics in
358 Central Equatoria State, and, in Unity State, discouraged returnees from continuing contraception
359 they had been using for years in Khartoum, claiming a different set of laws and norms existed in
360 South Sudan.

361 Such confrontations limit women's options, but also, sometimes, transform men into unlikely
362 advocates of family planning. Providers from several family planning organisations told stories about
363 husbands who initially threatened them becoming "very good friends" of the organisation and
364 promoting their services to others after having the chance to discuss contraceptives in detail at the
365 clinic. Policy actors also identified politicians who have attended family planning workshops and
366 come back "completely converted," as one of them put it. But this is an unpredictable situation.
367 Consequently, before providing contraception, many health workers seek to verify that a woman has
368 her husband's consent, even going so far as to request men's phone numbers to confirm it. As one
369 provider explained: "a midwife's first question is always, 'have you talked to your husband?'"

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370 Abortion services engender even stronger tensions than contraception. As with secret contraceptive
371 use, if a woman is discovered to have procured an abortion, she will often be punished; the "beating
372 can go all the way to the health centre" to intimidate providers, claimed a representative of an
373 international organisation. Police, routinely stationed at large hospitals to resolve disputes, may
374 intervene in such instances but also contribute to an atmosphere in which providers admit they
375 sometimes feel compelled to report induced abortion during the course of treatment.

376 This may help explain why women in cities like Juba often seek abortions and post-abortion care
377 from private sector providers, particularly those operated by foreigners, where both government
378 and social surveillance is less intrusive. However, people who oppose abortion occasionally force
379 activities in the private sector into the political space of public hospitals. In 2012, an article in a
380 prominent daily newspaper reported that a local politician abducted and unlawfully detained health
381 workers from a private clinic he suspected of performing a "secret abortion" on his female relative,
382 bringing them and the patient to Juba Teaching Hospital. Part of the moral authority he appealed to
383 related to the type of place his relative had sought the abortion, rather than the abortion itself,
384 reportedly saying: "I demanded to know why she was in a private clinic instead of a civil hospital"
385 (Sudan Tribune, 2012). Appealing to readers' patriotism, the implication here is that outside public
386 hospitals, the capacity of the new state to control or safeguard women's reproduction is critically at
387 stake.

388 Tensions also abound around international NGOs' work on reproductive health. During fieldwork,
389 rumours circulated that the government passively aggressively refused to renew a Memorandum of
390 Understanding required for one international family planning NGO to operate legally in the country
391 because it suspected the organisation to provide abortions illegally. Meanwhile, it allowed a
392 domestic family planning organisation closed by rebel leaders several years earlier to re-open. The
393 small number of international organisations supporting post-abortion care programmes have also
394 faced protest online (Baklinski, 2014; Dennis, 2012). Civil society bloggers have called for their

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395 greater regulation, pointing to a profound discomfort with the uncertainty created by the presence
396 of multiple strong, state-sanctioned discourses on reproduction. For example, in a post to a
397 diaspora-run blog site (Dennis, 2012), the author, a concerned citizen in the capital, appears morally
398 opposed to abortion, but ends by asking the government to resolve the ambiguities that cause
399 people to operate in secret:

400 *After 21 years of civil war in Sudan where millions of lives were lost, we would*
401 *imagine that the most logical programme for the world's youngest nation—South*
402 *Sudan, would be one that promotes population growth to replace the lost lives. …*
403 *Abortion is illegal in South Sudan and any organization or individual promoting*
404 *abortion is promoting an illegality … it is a bloody and murderous affair … The big*
405 *and urgent question is: for how long will this carnage continue? Or if it's the best*
406 *thing to have ever happened for our girls and women, then let the government*
407 *openly announce that they want to, or have already, legalize abortion … South*
408 *Sudanese must know because their love ones are dying under mysterious*
409 *circumstances, all under the nose of a seemingly dysfunctional government in*
410 *Juba and beyond the reach of the law! [sic]*

411 The author implies that the ruling SPLM has lost much of its legitimacy as parts of South Sudan have
412 slid back into internal ethnic conflict in the last two years. Within this context, nationalist rhetoric
413 seems less enchanting. A domestic policy analyst claimed that, increasingly, people are dismissing
414 the population replacement discourse as SPLA propaganda, particularly ethnic groups from the
415 southern Equatorian states not directly involved in the current crisis. The crisis has also provided
416 political space for some politicians to justify the Ministry of Health/donor discourse, as illustrated by
417 the question one parliamentarian poses in his efforts to lobby support for family planning
418 organisations privately with other politicians and local authorities: "if leaders are not taking

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419 responsibility for the bad behaviours of their constituents who are keeping the country at war, how
420 can they be expected to promote healthy behaviours like family planning?"

421 Sanctuary & surveillance in Protection of Civilians camps

422 The ethnic character of today's conflict has amplified reproductive surveillance of displaced women
423 and the importance of population replacement to some ethnic rebel movements. Simultaneously,
424 crisis-response NGOs have accelerated family planning interventions in UN Protection of Civilians
425 camps, a type of uniquely protected humanitarian space requiring little negotiation with domestic
426 governments. Here, tensions between competing discourses and practices have come to a head.

427 Relatively early on in the current crisis, international NGOs began offering short-term methods of
428 contraception to populations living in UN camps, giving women who previously had to visit tertiary
429 health facilities or private pharmacies to access such commodities easy and free access. Accordingly,
430 women elders in one camp said they were counselling younger women to treat this situation of
431 extraordinary access as a learning opportunity, saying "before going back to the village, we want to
432 know how to use this medicine safely". Camp statistics so far, however, indicate relatively low
433 uptake. For example, clinic staff at one camp visited in Juba in 2014 reported between 0 and 11
434 family planning service users per month for a population of around 13,000 people.

435 Stories from the camp suggest a number of possible explanations for such low uptake. Nuer women
436 who have sought refuge in UN camps in Juba fled ethnically-motivated violence, including sexual
437 violence (CARE, 2014). A year on, Nuer people still feared leaving camps and felt widely persecuted
438 and suspicious of activities that could be associated with the Dinka-dominated state, including
439 international organisations who must cooperate with the state to operate. For example, encamped
440 communities turned away food aid suspected to be poisoned (Migiro, 2015) and some people
441 refused vaccines during a WHO-led cholera campaign, citing distrust of the agencies involved
442 (Peprah et al., 2016). In this context of conspiracy and fear, international organisation

443 representatives recalled that the introduction of family planning commodities into camp health
444 services were protested as another attack on the well-being of the Nuer community; residents even
445 successfully lobbied to have one organisation pushed out of the camp for this reason.

446 Health workers reported that population replacement rhetoric had also re-emerged in camp
447 discourses, with comments such as “we need to make more Nuer fighters” shared by some men at
448 meetings and on social media. On the other hand, an older women’s group leader explained that
449 women feared pregnancy in the poor camp conditions and considered pregnancy as “something for
450 the future”. This, however, did not translate into popular recognition of a need for modern family
451 planning or abortion. Both remained greatly stigmatised, conceptualised as services required only by
452 women who were having extra-marital affairs. Young women whose husbands were away fighting
453 were the target of roving information campaigns, but could not legitimately use them, she claimed,
454 or people would say, “why do you need it, you are taking it [contraception] for whom?”.

455 Inter-clan conflicts also erupted in camps when pregnancy evoked suspicions of adultery or when
456 women were discovered to have induced abortions. Referring to one widely known incident,
457 another women’s leader showed photos she had taken of a foetus retrieved from a communal
458 latrine. She claimed that the woman procured an abortifacient outside the camp, induced the
459 abortion in her tent and then was obliged to dispose of the foetus in the latrine. The woman’s
460 husband was absent and neighbours had severely beaten her upon discovery for both the abortion
461 and the assumed adultery. International organisations have reported similar events in other UN
462 camps populated by Nuer and other ethnic groups (Radio Tamazuj, 2014). Thus, as one NGO
463 representative explained, in the tense confines of camps, there was a need for post-abortion care -
464 “*a lot*, by international standards”- both to deal with unsafe abortions and the collateral social
465 effects. In the close confines of camp life, women’s use of state- and NGO-sanctioned contraception
466 and abortion services is met by neighbours’ surveillance and sanctioning on behalf of the ethnic

467 group when husbands are away fighting. Where ideologies are being violently negotiated, such
468 services are thus unintentionally inviting violence onto users.

469 Conclusion

470 South Sudan is in dramatic flux as new national, ethnic, gender and personal identities are being
471 forged. Recovery from war necessitates reconciling cultural differences accrued through processes
472 of militarisation, displacement into neighbouring cultures and exposure to globalism and
473 humanitarianism (Grabksa, 2014; Hammond, 2004). The post-conflict context thus provides a
474 valuable window into many contested cultural and political domains, including reproductive health,
475 and the way in which the expansion of social policy and services becomes an integral part of peace-
476 and nation-building efforts.

477 Our analysis shows that reproductive health discourses have been actively shaped by rapidly
478 evolving institutions in ways that appeal to South Sudanese peoples' aspirations to live in a country
479 of their own making. The competing nature of these discourses demonstrate the incoherence of
480 South Sudan's current nation-building project: the State in effect has incomplete control of the
481 nation(s) within its borders and this larger cultural battle between customary, militarised and
482 modernised ideologies is expressed as contestation and even violence.

483 Humanitarian organisations have recently been criticised for neglecting to integrate family planning
484 and abortion services in crisis responses due to political and donor sensitivities; insufficient
485 understanding of abortion legality; a tendency to see the services as a 'development' rather than
486 'emergency' need; and a perception that the services are complicated to provide or that they are
487 not needed (Casey & McGinn, 2016; Tanabe et al., 2015). Here, we have shown that an additional
488 reason is NGO workers' perception that family planning and abortion services are not wanted by the
489 population and even constitute a security and political risk to organisations and their ability to
490 provide other priority interventions.

491 Sexual violence can provide a 'comfortable' justification with which humanitarian organisations can
492 provide abortion services in crises (Casey & McGinn, 2016). Our observations in UN camps support
493 this idea: international organisations have begun justifying the need for abortion in relation to rape
494 (Radio Tamazuj, 2014), but they have been publicly silent on the potential that pregnancy
495 prevention or abortion may be associated with consensual sex. Reproductive surveillance in
496 displaced person camps, which we understand as a form of reproductive control, has also been
497 under-appreciated here and, potentially, globally (see, for example, omissions in Hudson (2016)).

498 Given that health workers deal directly with patients in distress, health facilities may be particularly
499 'permeable' spaces where the effects of violence experienced in wider society are easily felt (di
500 Martino, 2002). Our analysis is one of few to show that gender-based violence and violence towards
501 health workers can be a potential *outcome* of family planning and abortion services, especially when
502 used clandestinely (see also Bawah et al. (1999)). Additionally, we have shown how intra-communal
503 violence can be an unintended outcome of these services in contexts of post-conflict nation-building.
504 The conceptualisation of reproductive health services as a risk to cultural systems is not unique to
505 post-conflict settings, but is especially clear in South Sudan where there has been so little exposure
506 to modern health services. Men's sometimes violent resistance to modern contraceptives reflects
507 not only patriarchal attitudes, but also their view of such technologies as foreign and therefore
508 threatening to South Sudanese identity. Kurds, as minorities in Turkey, are similarly resistant to
509 government-advocated family planning and caesarean-section deliveries because they are seen as
510 technologies of cultural assimilation (Erten, 2015). In clinical settings, supporting women to use
511 contraception or undergo abortion in secret may be an appropriate individual-level harm-reduction
512 approach to violence from male partners (Miller & Silverman, 2010; Moore et al., 2010). Such
513 clandestine behaviour may appear as capitulation to the dominant ideology behind customary and
514 military discourses. Alternatively, it can also be seen as an act of resistance or resilience pursued by
515 relatively powerless individuals; an unavoidable necessity when resolution of competing discourses
516 in the near term is unlikely (Grabksa, 2014; Wirtz et al., 2014).

517 In complex post-conflict settings like South Sudan, policy and interventions related to family
518 planning and abortion thus invite contestation, resistance and even violence. Understanding the
519 political, social and historical discrepancies and tensions between competing discourses is essential
520 to understanding behaviour and the uptake (or lack thereof) of new policies and programmes.
521 Further research should examine women's reactions to policy change, the cultural, structural and
522 other reasons why women use services (or not), as well as the sustainability of donor-funded
523 initiatives to increase family planning in light of their current tensions with cultural ideals. Women's
524 groups, in particular, should be involved in making sense of nation-building discourses, to shape
525 both the construction of problems related to women's reproduction and their solutions. State and
526 NGO actors should work with women to meet safety, accessibility and dignity standards in delivering
527 abortion and family planning programmes. They should also collaborate with social protection
528 initiatives to mitigate and respond to interpersonal and communal violence against women in real
529 time (Global Protection Cluster, 2014). While reproductive surveillance, control and violence may be
530 expected during war, its roots transcend war and peace (Scheper-Hughes & Bourgois, 2004) and so
531 should be anticipated during peace-building processes, too.

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Research highlights

- In post-conflict South Sudan, institutions are reorganising, identities shifting
- Humanitarian family planning discourses clash with customary and military ideals
- Peace-building, which includes family planning, leads to unexpected gender violence
- Social groups are policing reproductive decision-making in displaced person camps

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