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Jennifer J. Palmer, Katerini T. Storeng

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

Authors & affiliations: Jennifer J Palmer[1,2] & Katerini T Storeng[1,3]

[1]Department of Infectious Diseases Epidemiology, Faculty of Epidemiology & Population Health, London School of Hygiene & Tropical Medicine, United Kingdom

[2]Centre of African Studies, School of Political & Social Sciences, University of Edinburgh, United Kingdom

[3]Centre for Development and the Environment, University of Oslo, Norway

Corresponding author: Jennifer J Palmer (jennifer.palmer@lshtm.ac.uk)

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

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.

Introduction

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

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

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

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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

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

5

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.

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.

7

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

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

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

11

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

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..."

14

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?'"

16

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

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

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?"

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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724

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