KIT | Health

Community Participation Programme

End Report

SOUTH SUDAN HEALTH ACTION AND RESEARCH PROJECT

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REBUILDING COMMUNITY TRUST

Contents

Acronyms and abbreviations

ANC	Antenatal care
CPO	Community participation officer
CHD	County Health Department
FGD	Focus group discussion
HHP	Home health promoter
HIV	Human Immunodeficiency Virus
IDP	Internally displaced people
IMC	International Medical Corps
KII	Key informant interview
KIT	Royal Tropical Institute
NBeG	Northern Bahr el Ghazal
MOH	Ministry of Health
PNC	Postnatal care
SHARP	South Sudan Health Action and Research Project
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TBA	Traditional birth attendant
VHC	Village health committee
WBeG	Western Bahr el Ghazal

1. Community Participation Programme

1.1 Introduction

The South Sudan Health Action and Research Project (SHARP), implemented by the Ministry of Health (MoH) of South Sudan, the Royal Tropical Institute (KIT), HealthNet TPO, the International Medical Corps (IMC) and Cordaid, aims to improve maternal health in South Sudan. An assessment pointed to a number of barriers to timely access antenatal, delivery and postnatal care and dominant socio-gender norms related to sexual and reproductive health (SRH)[1]. In response, SHARP developed a community participation programme. This programme adopted an action learning methodology for knowledge transfer, reflection, intergenerational dialogues and the development of action plans. The programme has been implemented between 2014 and 2016 in Wau county, Western Bahr el Ghazal (WBeG) and in Aweil north county, Northern Bahr el Ghazal (NBeG). SHARP also conducted research in Wau county into norms, preferences and expectations of communities with regard to reproductive health services[2].

This end report provides insights into changes, with regard to SRH, that communities have experienced after having been part of the SHARP community participation programme. Data has been gathered during community baseline consultations, evaluation meetings and community end-line consultations. The community consultations and part of the evaluation meetings have been held with the community members who were part of the programme. Lessons learned are abstracted, which provide insights for future programming. These insights are valuable when applying similar methodologies to engage community members in understanding SRH and influencing actions at the community and health facility level; and therefore improving their SRH.

1.2 The objectives of this end report

- To summarise the changes, with regard to SRH seeking behaviour and related issues, that community members and facilitators have experienced.
- To abstract lessons for future implementation of community participation programmes that touch upon the concerns and challenges faced within the communities.
- To abstract lessons with regard to the process of implementation of the community participation programme.
- To reflect on these lessons and outcomes, and provide recommendations for future similar programming.

1.3 Methodology

As part of the community participation programme, community baseline consultations, community evaluative meetings with engaged communities, facilitators and community end-line consultations were held. Half of these meetings have been consistently reported. Besides baseline, end-line and batch[3] reports, also review meetings and dissemination sessions have been documented. The following table shows the number of available reports that have been analysed for this end report.

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[1] Understanding knowledge, attitudes, beliefs, and practices around reproductive, maternal, neonatal, and child health in South Sudan. BBC Media Action: Reproductive, maternal, neonatal and child health project, 2013.

[2] Speaking to men's sense of responsibility. Key to improving reproductive health in South Sudan. Policy brief 1 July 2015. KIT Health, International Medical Corps, University of Bahr el Ghazal.
Ensuring financial access to quality care. Key to improving reproductive health in South Sudan. Policy brief 2 July 2015. KIT Health, International Medical Corps, University of Bahr el Ghazal.

[3] Community dialogues were conducted in batches. For each batch, four communities were engaged where the community dialogues were conducted. A batch report provides a summary of the first outcomes of the community dialogue within those four communities after the community dialogues have taken place.

Available reports:	NBeG	WBeG
Baseline transcripts	5	8
Batch reports	4	2
Community participation programme format	4	0
Reports review meeting community participation	1	1
Public meeting after community dialogues in Bussere	0	1
End-line transcripts	12	0
Training of community participation officers reports	1	1
Training of community facilitators reports	1	1
Summary reports of community facilitators trainings	1	1
Dissemination of dialogue experiences at Women Deliver and South Africa Alada conferences	1	1

The evaluation was conducted using a qualitative methodology. Transcripts and reports were analysed using a coding framework in Nvivo. The coding framework was based on the topic guides for base- and end-line consultations. The topic guides can be found in the manual for community facilitators. The coding framework was adjusted based on emerging themes during analysis. After coding, narratives were written on the major themes.

1.4 The community participation programme

The objectives of the community participation programme were:

- To improve health-seeking behaviour of the community with regard to maternal health care services, including increased use of family planning.
- To increase capacity of local officials, health workers and communities to fulfil their roles and responsibilities in achieving sexual and reproductive health and rights (SRHR).
- To improve collaboration between the community and health workers in identifying issues related to SRH service delivery and to improve action regarding constraints in access to or quality of care.

The methodology of the community participation programme focuses on four elements:

1. The interaction between generations in the community, to enhance dialogue about maternal health. To enable dialogue between generations, participants of community-based dialogue sessions - which are facilitated by trained and voluntary facilitators from the communities - include younger and older men and women, and boys and girls. Participants are recruited from the community using existing groups, such as women's and youth groups.
2. Participatory learning and action dialogues that include small group work, plenary discussions, questions for reflection, and discussion of desired changes are used to address underlying norms and values and develop action plans for change.
3. Participatory rural appraisal visualisation techniques, such as social mapping, drawing and constructing matrixes are used to produce and visualise information for further discussion and analysis.
4. A knowledge component consists of the dissemination of information using two way communication techniques. This techniques are used to generate knowledge about danger signs, the benefits of using reproductive health services, the influence of age, number of children and birth spacing on maternal and child health, the right to services, what to do to have a healthy pregnancy, delivery and postnatal care, improving birth preparedness, the use of contraceptives and prevention of early pregnancy.

The SHARP community participation programme complemented other community activities implemented by the partners in Northern Bahr el Gazal and Western Bahr el Gazal, which included the training of home health promoters (HHPs) and traditional birth attendants (TBAs), training of village health committees (VHCs), peer education and general information and education activities. The programme made use of the same or similar learning aids that the HHPs use to introduce and reinforce the knowledge component. The programme aimed to contribute to improved maternal health, adolescent SRHR and youth friendly services, through promoting an environment for better communication between generations and between males and females.

The community facilitators facilitated community dialogues for improving maternal health, using participatory action and learning techniques. The first trainings of community facilitators was carried out by KIT at the end of 2014, with the support of IMC and HealthNet TPO, in collaboration with the County Health Departments (CHDs) in Wau County (WBeG) and Aweil North County (NBeG). After this initial phase, in 2015, the trainings were carried out by South Sudanese community participation officers (CPOs) of IMC and HealthNet TPO in collaboration with community facilitators.

A training of community facilitators

1.5 Overview community dialogue steps and sessions

This section provides a brief overview of the steps involved in the community participation programme.

Step 1: Curriculum development workshop

SHARP held a three-day curriculum development workshop in July 2014. This workshop included stakeholders who are closely involved in maternal health programmes conducted in the areas of

implementation of the community participation programme. During this workshop, the manual and materials for training of CPOs and community facilitators were further developed.

Step 2: Stakeholder meetings

Introductory stakeholder meetings were held to present the community participation programme to district-, *payam-*[4] and *boma-*[5] level decision makers, to ensure their support and to prepare for the selection of community facilitators. Four separate meetings were held at the *payam* level, as in every batch[6], four *payams* (and thus four communities) were included in the programme. The implementation sites were selected based on the following criteria: staff availability, health facility availability and the security situation. Urban/rural considerations were also taken into account as selection variation criterion.

Step 3: Selection of community facilitators

Community facilitators were selected in each of the four communities per batch: one older and one younger male and one older and one younger female. At the end of the process the community was asked to prepare for the selection of participants (step 5).

Step 4: Training of community facilitators

South Sudanese CPOs, whom received a training of trainers from KIT, facilitated all the seven days trainings of community facilitators. In each training, 16 community facilitators were trained: four from each community.

Step 5: Selection of community participants

Forty community participants were selected by the community: 10 younger and 10 older males and 10 younger and 10 older females. The community facilitators guided the selection of participants, after they were trained.

Step 6: Community baseline consultations

The community facilitators held initial group discussions with the selected young women, older women, young men and older men from the community to learn about their views regarding maternal health and birth spacing. These baseline consultations have been recorded and analysed for this end line report.

Step 7: Community dialogue sessions

The facilitators' teams in each community consisted of two CPOs and four community facilitators who completed the training of facilitators. The teams held five consecutive dialogue sessions with 20 young and older women and 20 young and older men from each community, who were selected in step 5. Every week, a new session was conducted in each community, and the sessions lasted approximately half a day. During the sessions, facilitators and participants worked in same sex groups, except for session 4. The dialogue sessions cover different topics and are concluded by meeting 6: a public meeting.

[4] Area with various villages.
[5] Village.
[6] In both NBeG and WBeG, the programme was conducted in batches of four communities, and in every community 40 community members participated in the sessions, facilitated by four voluntary community facilitators and two CPOs.

Overview of sessions

1. Practicing listening and dialogue skills
2. SRH in the life cycle; concerns we have; gaps in services
3. What do we know about improving maternal health and what are the causes of maternal mortality: antenatal care (ANC), birth preparedness, complications during pregnancy and delivery, postnatal care (PNC) and family planning
4. Entitlements, barriers and delays in maternal health
5. Preparing presentations for the whole community, including their suggestions, commitments and requests; evaluation of process
6. Public meeting, including presentation of action plan

Step 8: Follow up period community

After the dialogue sessions, the follow-up period is essential to improve maternal and neonatal health. Change can only be achieved when participants start putting their new skills and knowledge into practice and making change possible. Community facilitators had the task to support and encourage the participants throughout this period by meeting participants on a regular basis, individually and collectively.

Step 9: Evaluation

After six months, the CPOs together with external researchers who were familiar with the area held separate end-line consultations. These consultations were held with young women, older women, young men and older men from the community to learn about their views regarding the developments resulting from the dialogues, with the hope that communities continue to use the process beyond the programme. The end-line consultation signalled the formal end of the involvement of the partners (IMC and HealthNet TPO).

1.6 Overview of engaged villages and data acquired

In total 28 communities have joined the community dialogues over a period of two years (see the below overview). 16 villages in NBeG have been reached and eight villages in WBeG. All the outcomes of the community dialogues were documented in batch reports. Decisions and actions that were planned after the community dialogues with the communities have been described. Two community review meetings were held, where communities were visited to receive their feedback on the perceived changes. This occurred in Kabie and Aljazeera in WBeG. In NBeG, a community review meeting was held in Riang'anei and an IDP camp. In relation to the end-line, only in NBeG focus group discussions (FGDs) and key informant interviews (KIIs) have been conducted in four villages. Due to the security situation in WBeG it was not feasible to conduct an end-line there.

	County	Community	Nr of Participants	Baseline Report	Endline
1.	NBeG	Mabior Awenge	Batch 1	x	
2.	NBeG	Gowrayen	Batch 1	x	x
3.	NBeG	Riang'anei IDP camp	Batch 1		
4.	NBeg	Majak Bol	Batch 1		
5.	NBeG	Manyiel	Batch 2	x	
6.	NBeG	Mathiang	Batch 2	x	x
7.	NBeG	Majok Ajok	Batch 2	x	x
8.	NBeG	Mabior Nyang	Batch 2		
9.	NBeG	Ajok Anguei	Batch 3		
10.	NBeG	Lianager	Batch 3		
11.	NBeG	Majook Diing Wol	Batch 3		
12.	NBeG	Wunarwol	Batch 3		x
13.	NBeG	Rum marial jook	Batch 4		
14.	NBeG	Chew leek	Batch 4		
15.	NBeG	Warrapei	Batch 4		
16.	NBeG	Mangarayol	Batch 4		
17.	NBeG	Warthok village	Batch 5		
18.	NBeG	Burakuc	Batch 5		
19.	NBeG	Makwac Deng Ayom	Batch 5		
20.	NBeG	Lol Dit	Batch 5		
21.	WBeG	Agok	Batch 1	x	
22.	WBeG	Kabie	Batch 1	x	
23.	WBeG	Kpailie	Batch 1	x	
24.	WBeG	Ngo Alami B	Batch 1	x	
25.	WBeG	Biringi	Batch 2	x	
26.	WBeG	Aljazeera	Batch 2	x	
27.	WBeG	Gitan	Batch 2	x	
28.	WBeG	Bussere	Batch 2	x	

2. Results

2.1. Intergenerational communication

During the baseline sessions, many concerns were expressed by the older generation of women and men on their communication with young people. The older generation saw the intergenerational communication as problematic. In the old, days girls and boys used to listen to the elders. They had respect for and would obey their parents. According to the older men and women, this situation had changed. Elders observed a lack of respect from young people, because children were no longer listening.

Old man: *I start from our time, the relationship between the elders and the youth was good. The elders respected the youth and the youth respected the elders. This began usually at home: if you had boys at home, they would sweep the compound and light fire in the evening, then the elders and the youth would sit together, and the elders would tell those stories.*

Several factors that had contributed to these changed ways of communication were mentioned. According to some elders, children were not listening because of outside influences of foreigners, but also because of the media, internet and movies.

Old man: *Life a long time ago was better than it is today. The children would fear the elders more. If a child is sent to the neighbour's house, he may rush quickly. If he gets food he may say he is satisfied, because he is educated from home, but now children don't respect their elders.*

I: *What do you think brought about this change?*
R: *It is what the government of today brings, which brings about the change.*
I: *What has the government brought that has changed?*
R: *The children watch TV, listen to CDs and have electronics. That is why they don't understand.*

Some elders blamed the young people for the changed communication, others were able to reflect on how the role of elders had also contributed to changes. Some women and men mentioned the war in South Sudan and the poverty situation that have contributed to children no longer listening to the elders. They reported that families do not always stay together anymore, which resulted in a change in how family matters are discussed and decided upon.

Old man: *Before things were more connected to our family, I not only sat with my father, but also my grandfather, we worked hard. When it was time to marry, we married who our parents told us to marry and I still have my wife and I have a daughter. But what has changed now is not from the father or mother, it is either from the ongoing war, because a woman can look for a man alone and the man looks for a woman alone, the family is not the one that chooses. There is no fire light like before, because if I stay in a different home and the children in another home, nobody can light fire where the children gather to hear stories like before…*

Education was also reported as contributing to a shift of communication styles. Elderly felt that education has replaced the time that young people could sit with their parents. In the old days, families would gather together and light the fire in the evening to tell stories. Nowadays, the children are occupied with their homework, so there is no time to talk with each other. They felt that young people are too busy and speak a language they do not understand anymore. According to the elders, these days, boys and girls are also more influenced by their peers. This has led to worsened communication within families. As indicated in one of the batch reports:

Older people regarded schools as institutions for taming their children and encouraged enrolment, but are now regretting as they cited peer pressure as a contribution to lack of respect by youths to their parents.

The young men and women raised some points that are in line with the addressed causes of changed communication styles mentioned by elderly people. For instance, the poverty situation within the family and not being able for the family to meet the needs of the children, makes them to search for their needs through other means, namely transactional sex, and makes them no longer listen to their parents.

Young man: *The reason why girls leave home is from the elders, because if she says she wants a pen or exercise book, nobody can give her, so when she does not get any way then you may go to the street and do a lot of things, this comes from the people at home.*

Problems like alcohol abuse in the homes, where situations arose of children being insulted, were mentioned as factors that constrained communication for young people with their parents.

Young woman: *The reason why the children don't listen to their parents is from the father or the mother. Because he or she may drink and comes and tells you what you don't understand. He or she may insult you and tell you that you are a fool, you are a prostitute and so on. This is the reason why children don't listen.*

Also the experienced peer pressure amongst youth contributed to the disobedience of parents:

Young woman*: As an adolescent girl, the boys keep convincing me to be their friend, while my parents are warning me that I can be easily pregnant if I engage with boys*.

Some young people were capable to express that elders play a part in it too.

Young man: *Young people we are not bad. The world has changed and that is why the elders are saying, we are bad. In the past, people were wearing goat and sheep skin and walking without shoes. But now there are different types of shoes and different styles of clothes to wear. We know what is wrong and what is good, but old people are just saying young people are not good. Do you think that when you are saying to your child you are not good, that the child will change? Unless you sit down and explain the wrong she or he did and will understand that she or he is wrong. We are all there during the market day, we are all with parents in the market, then who will say that is wrong and even when you have a problem and want to discuss with the old people they cannot understand what you want to say. They will just answer you, the young boy or girls of this you are not good enough to be listening to, because you make yourselves niggers*[7]*.*

During the community dialogues, the communication between the older and the younger women and men changed. Girls and boys became better listeners according to the elders:

Woman [FGD Women Mathiang]: *Before they did not listen to their mother, when their mother talks to them they would get mad and show attitudes, but after your advice they changed. They started to listen to their parents, especially when they talk to them about going out all the time.*

The young people noticed that they were respected more by their parents.

Young man: *I am one of the youth, after the teaching our parents changed the way they communicated with us, meaning they respect us and so we do too.*

[7] Niggers is a term used by and for young people who are part of juvenile youth groups in Wau county.

I: *Do you listen to old women?*
Young woman: *Yes, before they yelled at us and disrespected us, but now they respect us and talk nicely to us. The change in how we are treated caused a positive change in our relationship.*

Some community members felt they were reminded of the importance of listening. Previously adult men and women admitted they were not listening to teenagers but just giving them instructions. They learnt why their children were not listening to them. After having participated in communication exercises during the community dialogue sessions, they felt more confident in communicating effectively with other people.

In both states, the community dialogues contributed to the increased capability of men, women, girls and boys to express themselves. Before the community dialogues, mainly the girls and boys and women were not accustomed to speaking in public. During the community dialogues they learnt to express themselves in public, and men were accepting this as well. As stated in the community dialogue report batch 1 WBeG:

For many young people it was the first time they were expressing themselves publicly. Young girls and boys were shy to speak their minds or introduce themselves. Generally they were happy that the participants had learned these new skills and they will use them to change the community. They felt if someone listens to you, you get motivated to share more and open up. Additionally the participants were able to identify signs of good listening. They were also able to identify verbal and nonverbal communication during their practice.

A dialogue session in NBeG, Riang'anei IDP community

2.2 Danger signs: knowledge and actions taken

Maternal mortality is high in the communities in Western and Northern Bahr el Ghazal. Danger signs during pregnancy are sometimes explained from a biological point of view, other times traditional beliefs play a role. During the baseline sessions with the communities, it became clear that some people were more knowledgeable than others about danger signs and what kind of actions to take. Some older women and men made use of traditional medicine to address the health situation of pregnant women.

Young woman: *When you are pregnant, there are many beliefs which say you should not work, or go near the fire, sometimes people will tell that sleeping a lot is bad, because this can cause a lot of water into the womb and causes internal bleeding.*
I: *Do you believe that a lot of rest during pregnancy can cause bleeding after birth?*
Young woman: *Yes, it can affect the unborn baby.*

As a response to danger signs, most participants indicated to take pregnant women to the health facility, and go for pre-natal check-ups. They acknowledged the importance of going to the health facility in case of weight loss, severe bleeding, swelling, malnutrition and dehydration and that pregnant women should not conduct heavy work. Several women knew well what the causes of the bleeding are, when they are not spacing their children or do not go for antenatal care to know how the mother and baby are doing.

Woman [Baseline Kabi]: *This is caused by the fact that when a woman is still breastfeeding and she decides to get pregnant again too soon then this can cause bleeding and create belly pain. A girl should give birth when her child is big enough but the girls of today may get pregnant under age. This is what causes the bleeding.*

Woman: *The bleeding happens because the pregnant woman does not go to the hospital; if she does not go to hospital that is why there is bleeding.*
Woman: *Bleeding is caused by carrying heavy loads; heavy work is what can cause internal bleeding.*

A range of traditional beliefs existed in relation to the prevention of obstructed labour and/or complications during pregnancy and labour. For example, there were quite a number of beliefs about the food intake of a pregnant women that can cause miscarriages. Various types of food that pregnant women should not eat were mentioned, like mud fish, chicken soup, crocodile, baboon, snakes, bitter fruit and rat.

Woman [Baseline consultation Aljazeera]: *Sometimes when a woman is pregnant she may be told not to eat baboon.*
I: *What is the relationship between pregnancy and baboon?*
Woman: *That when you eat then your baby will look like a baboon.*
2nd woman: *There are certain fish which you should not eat.*
3rd woman: *A woman should not eat a rat too.*
I: *What is the reason when a woman is pregnant she should not eat a rat?*
Woman: *That when a woman eats a rat, this might cause miscarriage.*

I: *What do you think is the reason for a woman should not eat this or that?*
Chief: *This is because it is the tradition of her husband.*
I: *When a pregnant woman eats a bird what do you think happens to her?*
Chief: *It is the elders who know about this….[laughter]. During delivery the baby might come out and in.*

There was also the belief that women should not eat a lot, to keep the baby small, and to prevent obstructed labour. Generally it was believed that babies should be small to support easy delivery, therefore nutritious food should not be taken by a pregnant women, and they should work hard for long hours in the sun, so the baby should not become too big.

Man: *Pregnancy in our community is treated as a special moment for the family and all precautions are taken to ensure a safe delivery as we know that the baby will be the future of tomorrow. To do this the woman is not allowed to sit or work under the shade instead she should be asked to walk in the sun to allow the blood to flow and keep her active so the baby doesn't grow fat and give her problems during delivery.*

Other cultural beliefs were connected to obstructed labour. When obstructed labour or bleeding takes place, girls and women in delivery are blamed for being promiscuous.

Man: *This bleeding is caused by those girls who move a lot from here to there looking for money, the blood she is receiving from these different men, is what causes the bleeding.*

In case of obstructed labour, community participants explained of a belief of husbands seeing labour obstruction as a sign of not being the father of the baby.

Man [Baseline consultation Aljazeera]: *Long ago sometimes when a baby refused to come out; this might be from the customs and tradition of a man. Maybe this is not the baby of the man; that is why the baby might not come out. Unless he has to forgive this and open the cervix, then the baby may come out.*

I: *How will you know that a baby which refuses to be born is not of the man?*
Woman: *This is caused when a man marries a woman in a bright daylight with hoes and you decided to go somewhere and then when you get pregnant then this baby might not come out…., unless they take a chicken then they perform custom and tradition and then the child would come out.*

Man [Bussere Baseline]: *Another tradition is when a woman delivers, she would call the names of all the men that she slept with. Then little pieces of sticks are cut and tied to the neck of the baby.*

This belief had severe consequences for women and their babies. It contributed to women not being allowed to go the hospital or another health facility during obstructed labour, instead they should confess the names of men with whom they slept. After this, it was believed that the obstruction would stop and delivery could naturally continue at home.

Man [Bussere Baseline]: *There are other tribes who may not allow their wives to deliver in the hospital, only at home, because if a woman has sex with another man, she will have to confess so that they may take a lawful procedure against her.*

The respondents were also providing some examples of traditional practices that would encourage the baby to come out of the womb.

Old man: *If the baby refuses to come out the man may step down his feet three times until the baby comes out. It is the husband who steps down three times, that means my wife should be alive.*
I: *How do you step down?*
Old man: *You just step down only until the baby is born.*
I: *What is the reason for stepping down your feet?*
Old man: *The reason is because the baby refused to come out.*

In case the placenta retains other cultural practices were applied.

Woman: *I heard from my grandmother that when the placenta refuses to come out, a cook rod is put into the mouth of a woman, then she may have hiccups until the placenta comes out.*
2nd Woman: *A key of a room can also be put into the mouth and then you open her mouth with it as if you are opening the door, then it will come out. This is used by the people of the past I don't know why.*
3rd woman: *This is a tradition of long ago.*

Woman: *We can mix soap and water and give it to the delivering mother to drink, so that the placenta will come out.*

During session 3, community members became more knowledgeable about the danger signs. They became aware about causes of maternal death. Many community members thought that maternal death was caused by witchcraft, and by women not being faithful to their husbands. However, it was noted that nowadays the communities seem to be more knowledgeable about danger signs and saw the need to go or take their wife to the health facility.

The communities were appreciating the knowledge and awareness that was created during the danger signs session. For follow-up, many took up the learning to share during the public meeting, as a result the wider community could benefit from it. Overall, there was an increased understanding over the course of the programme about the dangers of home delivery. Many community members were positive about the danger signs session: it was an eye opener to many.

Man: [End-line FGD Men Majok Akok]: *I think the health education teaching is responsible for everything good that is happening in our community. Pregnant women became very careful about their lives, visiting the facility for their check up, and having their babies at the facility rather than at home, all those processes reduce the bleeding, suffering, and death among the pregnant women.*

During the end-line FGDs, men, women and chiefs acknowledged that more women and girls visited antenatal clinics and gave birth at the health facilities, including those who were not part of the community dialogues.

[End-line Women FGD] I: *Is there any woman, who had her baby at home since the health education teaching?*
Woman: *After the teaching all women started to go to the facility for check-up and follow-up until they delivered their babies.*

[End-line FGD Men] I: *What do women have to do to keep themselves healthy?*
Man: *Our life before the teaching was very bad we were blind but after everything changed. Pregnant women began to go to the hospital for check-ups, children became good listeners to their parents.*

Chief [End-line KII Chief]: *I do know about the programme because when they started it was a very good plan for the people in my community. They learned a lot from the teachings that took place here. Indeed, I am so thankful for the huge change that happened. I believe that this is how change comes, from people like you. I think that the health education teachings helped our women to learn how to take care of themselves and their children. Pregnant women began to go to check-ups and follow up with their pregnancy monthly until they deliver their baby.*

In addition, chiefs acknowledged the importance of the community dialogues and the health of pregnant women.

Chief [End-line KII Chief]: *The programme took place last year; it was about the health education teaching, the participants taught our pregnant women how to care about themselves and stay healthy during their pregnancy by visiting the facility every now and then for their check-ups until their delivery,*

also our young girls learned how important it is to finish school and to have a better future. So the teaching changed the whole community.

Community dialogues in a church in Aweil North County

2.3 Use of family planning methods

Decision making in relation to family planning was mainly considered as a decision in the hands of God. Religious motivation is in line with the dominant culture and beliefs, that women and girls have to fulfil their reproductive role in society. After God it is men who decide on the possibilities of family planning. A frequently used argument against family planning is the bride price practice. Men have paid a bride price and because of this, they have the right to decide on the number of children. However, reproduction is not considered as infinite. In general, men are seen to have a responsibility to cater for the wellbeing of the wife and the children. If men are not providing for basic needs and education, family planning becomes a possibility.

In some cases, it were women who can decide together with their partner to make use of family planning methods, when she delivered already up to five to six children. In case her husband did not want to make use of family planning, some women were reported to make use of family planning in a secret way.

Woman: *Yes that is true we need to go to the hospital for family planning. Sometimes your husband will say no for protection, but you need to find a way to go to see a doctor so that you can get some pills. And if your husbands rejects, than you can get them without his knowledge.*

It was reported by men and women that family planning was a topic that can create conflict. Women have to obey to men when it comes to having sex and deciding to have children. When she does not obey, she can face violence in the relationship. Women reported that domestic violence can also take place when the husband discovers that his wife secretly makes use of family planning or refuses sex.

Community facilitator: *Besides their own values and norms [of health workers], some health workers are also reluctant to provide family planning because of fear. A health worker provided contraceptives*

to a lady, without notice of the husband. The husband found out and fought with the service provider. The service provider got arrested, and the ministry had to release him [from jail].

2.4 Child spacing

For the health and wellbeing of children and their mothers, child spacing has been a tradition in the communities. To be able to space the children, couples did not sleep together in the same house. The mother was breastfeeding for two to three years, to prevent pregnancies. In general it was perceived as a negative issue for women to be pregnant again before their baby could walk. To practice child spacing and for the wife to recover from the pregnancy, the husband - in case he can afford to pay another bride price - would marry another woman.

Man: *What is happening is that you don't go to a woman for two years [after delivery], the baby has to breastfeed for two years, and this is what can prevent pregnancy.*
I: *What do you do to ensure that a woman stays alone and you alone for two years? What will you do?*
Man: *you may go to another woman and leave this one.*

Child spacing was reported to happen less than in the old days, which also contributed to increased maternal death, especially when girls are pregnant at a young age and deliver too many babies after each other. One custom that has been introduced is referred to as the 40 days. During the baseline in Majok Akok, young men indicated that nowadays their wives are requesting for the 40 days. 40 days after giving birth sexual relationships continue. When the young men do not obey to the 40 days, the wife will not be happy. It could be possible that having sexual relationships after delivery is introduced for the husband to stay with the wife. At the same time these 40 days cause many pregnancies after each other, which can be dangerous for the women. The young men therefore indicated that family planning is required to reduce maternal death.

Still the majority of people during the baselines were less in favour of girls and young women making use of contraceptives, especially not in those communities where bride price practices take place. Making use of contraceptives before marriage was not accepted. Family planning was mainly accepted for married couples who need to space children for the health and wellbeing of the wife and the new-born child, or when they have already enough children.

Community participant [Baseline Mabior Awenge]: *We do not want young girls to take family planning or boys to take condoms. It is our tradition and culture and it will not allow young girls and boys to take the contraceptive pills or condoms. Why, because young girls if it's allowed to them to take contraceptive pills they can take it in the wrong way. Nobody will marry them again, because the girl who plays sex outside marriage, will be considered as a prostitute and we are hoping for the young girl to bring some cows.*

Due to stigma around the use of contraceptives, not only women, but also girls and boys made use of contraceptives secretly.

Young man [Baseline Gowrayen]: *Matters to do with family planning and birth spacing are never discussed in public and we are expected as young ones to remain single, though our parents allow us to go for drum. Here we are free to engage in sex and we end up impregnating girls, then we are blamed. Some mentioned the use of condoms to prevent pregnancy, but reported that if they are found they are scorned and at times punished by the family of the girl for using condoms on their daughters by paying a fine of seven cows. It is stigma in our community to use modern methods of family planning, as they associate this with promiscuity, so we do it secretly.*

During the end-line the acceptance for modern contraceptives amongst married couples was highest. Condom use was mainly stressed for young people during the end-line in NBeG, condoms boxes were installed and accessible at all facilities.

[End-line FGD Women Wunarwol] I: *How do you go to the hospital with your husband to get the family planning?*
Woman: *sometimes your husband will respect you and go with you. But some men find it shameful and refuse to go along.*
I: *do you tell your husband about it and wait for someone to bring the pills for you?*
Woman: *No if you want medicine for protection you go to the facility every Friday to bring your pills.*
Woman: *If he comes at night and asked me I say no to him. Or I tell him if you want me, we better go to the facility for family planning.*

In WBeG, in the summary report of the community participation training, more openness was expressed for young people to also make use of contraceptives if this was required. During one of the public meetings it was decided that condoms were to be made available to young people through the health facilities. However, participants in three villages indicated that there was no transport to the health facility, making it more difficult for young girls and boys to obtain condoms when they need them. It is unclear how follow up has been given to the improvement of accessibility of condoms for young people in these villages.

After the dialogues, some women accepted to start using modern contraceptives and men agreed to talk to their wives about the importance of child spacing for at least three years. Families agreed to talk to adolescents on how to prevent early pregnancy and sexual transmitted infections (STIs), HIV and delaying age of marriage to at least 25 years. Adolescent boys and girls said they would like to use condoms as they are already sexually active.

[End-Line FGD Women Majok Agok] I: *How do you prevent yourself during those years to not get pregnant?*
Woman: *Before you protect yourself by moving to a different room with your baby, but right now there are more ways to protect yourself, you can skip the fertile days after your period.*
Woman: *You can talk to your husband about the family planning, if he accepts that, then you can go to the facility and obtain medicines for protection.*
I: *what do you think of family planning?*
Woman: *I think it is good, it prevents to get pregnant and your baby will still be breastfed.*

After the community dialogues, participants became more receptive to the use of family planning methods to space their children and delay pregnancies for three years. They were more inclined to use injections than the oral pill, since participants reported that women tend to forget the latter.

[End-line FGD Wunarwol Men] I: *Do you think that husbands and wives go to the hospital for protection or are they still like before?*
Man: *Before some men and women go to the facility for family planning. It was a secret and they did it without letting anyone know, because it was very shameful to use family planning methods. But, now after the teachings everything is normal. Husbands and wives could go to the facility for family planning without feeling any shame.*

As indicated in the report from WBeG around batch 1 and batch 2, girls and boys were interested to use condoms to protect themselves from early pregnancy and STIs. Chiefs noticed that family planning reduced the occurrence of early pregnancy.

During the community review meeting of Batch 3 in NBeG, the chief was of the opinion that having many children without the necessary resources is a problem. The chief saw a role in convincing men not to have children anymore if a woman indicates that she does not want any more children. Especially in the case of medical problems, but also in case there are no medical issues. The chief was of the opinion that if the man still needs more children, he should be advised to take another wife. The chief believed that family planning kept mothers and children healthy.

Concerns about high teenage pregnancy were widespread: the importance of making contraceptives available for youth was agreed in all four communities in WBeG. The importance of putting a hold to conceiving many children was mainly mentioned by women and by some men as personal pledges**.** From the responses during the course of the programme, it became clear that communities have understood the complications of early and frequent pregnancies.

Woman: *For a change to happen, women should avoid frequent delivery and go for family planning and they should work to help because one hand cannot help. The man should be working and the women works on the other side because one hand cannot help, and frequent delivery should be abandoned, this is what can cause problems at home… this frequent delivery is what brings problems to the family and even the whole world.*

2.5 Teenage pregnancies and child marriages

Many different reasons were given on why early pregnancies and child marriage occur. Older respondents reported that nowadays girls get pregnant at a younger age, even at the age of 12 or 13. The incentive for girls to get pregnant or married at an early age can be to escape from economic hardship within their families.

Young girl: *Even mothers are quarrelling with their daughters. You do not want to help me with weeding, we can see where can you get a soap for washing your uniform? Then we will struggle when it is too much then we will decide to get married. That is why we are getting married early. And also sometimes the old people will say this young girl is getting older, why not get married.*

Child marriages were supported by some of the older generation. When girls have reached menarche the pressure to marry and have children increases.

[Baseline Gowrayen] respondent: *The moment a girl reaches menarche, the family becomes increasingly concerned and an aunty is identified to start preparing her for marriage, including child birth and spacing. They [girls] are frustrated by their parents, they feel the pressure to give birth to a baby. When you have a baby you are respected. So the mothers tell their girls to have a child soon. A woman should not be married at the age of 15.*

The pressure on marriage at a young age is caused by the existing norm for girls to get pregnant in wedlock. The bride price system strengthens this strict norm, by donating the bride's family more cows when the girl is still a virgin. Another norm that stimulates early marriages, is the younger the age of the girl the more children can be conceived and bigger families can be established. Big families used to be (and are often still) valued widely amongst South Sudan communities.

During the baseline in Gowrayen, the preference for young brides was clearly expressed by some men. They prefer to have sex with young girls as opposed to older women (referring to women of 20 years and above). The family of the bride would receive more cows for a young girl. She can give birth to more children if she starts earlier as opposed to those getting married above the age of 20 years.

If a girl becomes pregnant outside marriage, this reduces her potential to get married and the value of the bride price. Marriage is therefore very important, as an institutional protection mechanism where it is accepted for girls - whatever age - to have sex and become pregnant.

Another reason for early pregnancy was boys providing false promises to girls, to seduce girls into having sex. The boy sometimes promises that he can pay the bride price. After the girl becomes pregnant, the boy does not take the responsibility for the pregnancy. The boy will need to pay a fine or can get into jail.

I: *How about your son impregnating another girl?*
Men: *He would have brought shame to the family and a loss as we will have to pay seven cows to compensate for the fine. In some circumstances the girl is quite young and we only pay the fine and leave her to stay with her parents. It is however not a guarantee that she will be married by our son.*

Pregnancy can also be intended by the girl: when a girl wants to marry a certain boy, pregnancy can be a way to enforce the marriage. As stated in the review batch 1 and 2 report of NBeG, the elders indicated that girls wanted to get pregnant early, so they can be with the boy they like, or obtain some extra cows when a fine needs to be paid for the pregnancy out of wedlock.

The dialogue sessions brought a variety of insights to the community, to try to stop early marriages and pregnancies. Many participants never thought about the negative effects of early pregnancy for young women. To curb early pregnancies, in several communities agreements were made to delay marriages for girls at a young age, with a role of the village chiefs to monitor these agreements. Some communities in NBeG supported young people in having the right to choose whom to marry. The discussed advantages of choosing your own spouse were for couples to accept each other more and avoiding blame on the family when a relationship does not work out well. Furthermore, in some communities it was advised to not give the daughter away as a second wife, because husbands are nowadays less capable to carry the responsibilities when marrying two wives.

Chief [KII End-line Chief]: *There is a change in the young generation compared to the old generation, children are free: they go to school and to the hospital as well. Before there were some barriers between husband and wife, now a man helps his wife with the household duties. Even the daughter she is free, the father can't choose a husband for her anymore. The daughter has the right to choose who ever she wants and the boy is as well free.*

In WBeG, after the community dialogues evaluation, part of the older generation realized the need to advise their girls and boys to go to school. They should delay marriage and use family planning if they cannot wait to have sex. The younger generation said they will use condoms to avoid early pregnancy and STIs, while a minority of young people said they will concentrate on their studies.

Girl: *I think I learned a lot from the health education meeting, and how important it is for young girls to wait and finish their school so that they can have a better future.*
Woman [End-line FGD women]: *I think there is a big change, especially after your advice to us last year. Before the young girls went to a party and after a few months we would hear that a young girl had gotten pregnant, but now there is nothing like that.*
I: *How old do girls need to be to get married or pregnant?*
Woman: *Before it was 14 and less, but now everything has changed because the young girls learned how to go to the facility to get medicine for protection. Some of them listen to their parents because they want to finish their school.*

2.6 Bride price practices

In Northern and Western Bahr el Ghazal there is a difference in bride price practices. In NBeG within families, having girls is regarded as a greater treasure then having boys. Young girls contribute directly to the family wealth through a bride price of cows, when the girl is married off. In WBeG, the issue of bride price is not so prominent anymore and it is not paid through cows but with money. In WBeG boys are perceived as more important, due to their capability to maintain the family name through their offspring. In WBeG, it seemed that communities have less issues with girls and boys making use of contraceptives. Some wanted to reduce the height of the bride price, so boys can easily marry. These differences between bride price practices can be caused by the different livelihoods that prevail in these communities and the lifestyle that is connected to it. Wau is less rural and the main livelihood of Fertit people is subsistence farming, in Aweil North most of the communities are Dinka and pastoralists.

According to the men in WBeG, bride prices have increased, which makes it difficult for boys and men to get married and find a wife. During the life cycle session, men and boys expressed that the time to get married, is hardest for them. They need to marry and cannot raise the funds to pay dowry.

Men: *When you grow up as a boy of 15 then you begin to look for girls, the people of today if they go to ask after a girl, the dowry charged is very high, not to the extent that it can allow a person to get married. Long time ago if you paid 1500 you have married your wife completely, but now it is 35 million, 25 million, has God given us this girl so that we can count money like that? Where do the poor get the money from?*

After the community dialogues, one of the main actions highlighted amongst the communities in WBeG was to reduce the high bride prices, and for young people to encourage girls and boys when they are ready to marry to choose their partner.

Man [Bussere Baseline consultation]: *We expect Bussere [village] to change in terms of dowry. Dowry should be reduced a bit, because these years they say that you should pay 15 to 16 million and this is not good.*

During the pledges, one chief from WBeG informed the community to effectively change dowry practices. He suggested to have a chief's conference in the whole of Wau with other chiefs to thoughtfully discuss this issue, since reduction of dowry could also lead to young people marrying sooner.

The participants learnt about the life stages from the time of birth to the time of death. They discussed the cultural practices during the different stages for both men and women. These discussions opened up their minds on services needed at each stage. Communities realized limited services were provided to the adolescents in the community and the participants also acknowledged that youth were not getting adequate information to enable them to make informed decisions.

2.7 Expected roles of men and women

In a patriarchal society like South Sudan, men mostly make the decisions in the household and carry the responsibility to take care of their family.

Woman: *The rules at home especially according to the customs and tradition of South Sudan, it says a man is the head of the house, and he is responsible for everything. Long ago, any woman knew what her role was and the man also knew what was his. Then we said the roles of a woman is that the house work is hers from morning. For long ago, a man had to only go to the garden to cultivate, bring firewood, suffer and come back home and get everything ready.*

During the dialogues it was acknowledged that men could support women better and have a more equal division of workload.

[Men FGD End-line] I: *Do you think those duties will change?*
Man: *Yes right now they change, especially after the dialogue session, people learn about the relationships in the family. Men became a good helper to their wife, he can cook during her pregnancy and do more if needed. And women to help their husbands in their job.*

It was also mentioned that men should be in charge of the work division and carry the responsibility of the family.

[FGD end-line Men] I*: Who has the power to give women their responsibility, is it a man or a woman?*
Man: *The man is responsible to divide the responsibility between the wife and husband.*

2.8 Health decision making

Consistent with the general norm set, men were generally reported to have the responsibility to cater for their wives. As a result of carrying responsibilities, men also make decisions concerning the health situation of their wives. Decisions that block positive health outcomes were found to be often rooted in traditional beliefs or health services being regarded as too expensive. Decisions were also influenced by the mother-in-law.

Man: *I think there is no tradition that prevents a woman to go to the health centre, this is a decision made by the family.*
Man: *The man might say that when they go to the hospital and my wife delivers there, the health workers might demand for soap, 50 pounds and I don't have all these, so it is better for me to bring a traditional midwife so that she can help in the delivery of my wife at home. This is why women decide to deliver at home.*

Although many men were in charge of taking decisions around accessing health services, many men appeared not to be aware about women's health issues and made uninformed decisions based on certain beliefs that can obstruct the health of women.

Man: *Don't forget this delivery is natural, if a baby comes out with its leg or hands, water can be sprayed or fire is lightened, so it will go back inside and turns itself and comes out*.

[End-line FGD Women] I: *If you are pregnant, who is responsible of telling you to go to the hospital?*
Woman: *If you feel sick you can ask your husband to give you money, so that you can go and see your doctor. Or if the husband observes the changes happening to you, he can also take you to the hospital. Also your mother-in-law could help you, if she is strong she will take care of you.*

Before the community dialogues took place, men were often not aware that the dangerous situations like bleeding, obstructed labour, lack of nutritious food etc. can lead to death of women. During the end-line FGDs with women, men and the chiefs, emphasis was given to the necessity to bring pregnant women to the hospital and for husbands to take care of their pregnant wives' health.

Women: *Before husbands didn't care about their wives, but now things changed. If you are pregnant your husband cares for your health.*

I: *If the wife is complaining about any sickness, what does the husband do?*
Chief: *The man should take her to the hospital, so she can get diagnosed and get medicine.*

Furthermore chiefs and community leaders were advised by the community dialogue participants to develop a by-law to guide community members on actions to be taken on men who neglect their wives. (This would also have downsides, as poor men might be "punished" more than others).

2.9 Recommended changes

Overall recommended changes for the community to improve the maternal health were:

- Community members should prepare for delivery through saving money at the household level.
- All women should deliver in the health facility and attend ANC visits.
- Men should accompany their wives to the health facility.
- The government should ensure that health workers provide free health care services.
- The chief should punish men who neglect their women and children.
- Women should use modern contraceptives to space children for two to three years, in agreement with their husbands.
- VHCs should be involved in creating awareness on early marriage to neighbours, elders and their peer groups.
- Two communities wanted to start their own health facility. The community made a request towards the CHD for a health facility.
- In NBeG, one of the pledges focused on road maintenance by the youth, as a measure to improve accessibility of health services.

Overall giving birth at the health facility was seen as favourable, amongst others because of the provided birth certificate and the availability of misoprostol to stop bleeding.

2.10 Role of chiefs

The chiefs have an important role to play in relation to positive outcomes and commitments to action during and after the community dialogues. At end-line, the engaged chiefs understood the importance of preventing child marriages, teenage pregnancies and promoting the use of family planning and maternal health services.

However, some chiefs wanted to hold on to the older traditions, by advising couples to opt for two years separation after delivery to space children and to retain dowry payment. Another chief did not want to personally intervene on these issues, only when people would approach him.

[KII Chief] I: *If the husband and wife have a lot of kids, what do you think as a leader?*
Chief: *Our role is to intervene if they brought the cause to us, but we don't have any role to follow people in their home and know how many kids they have, what we do, we ask why do they have more kids and give advice.*

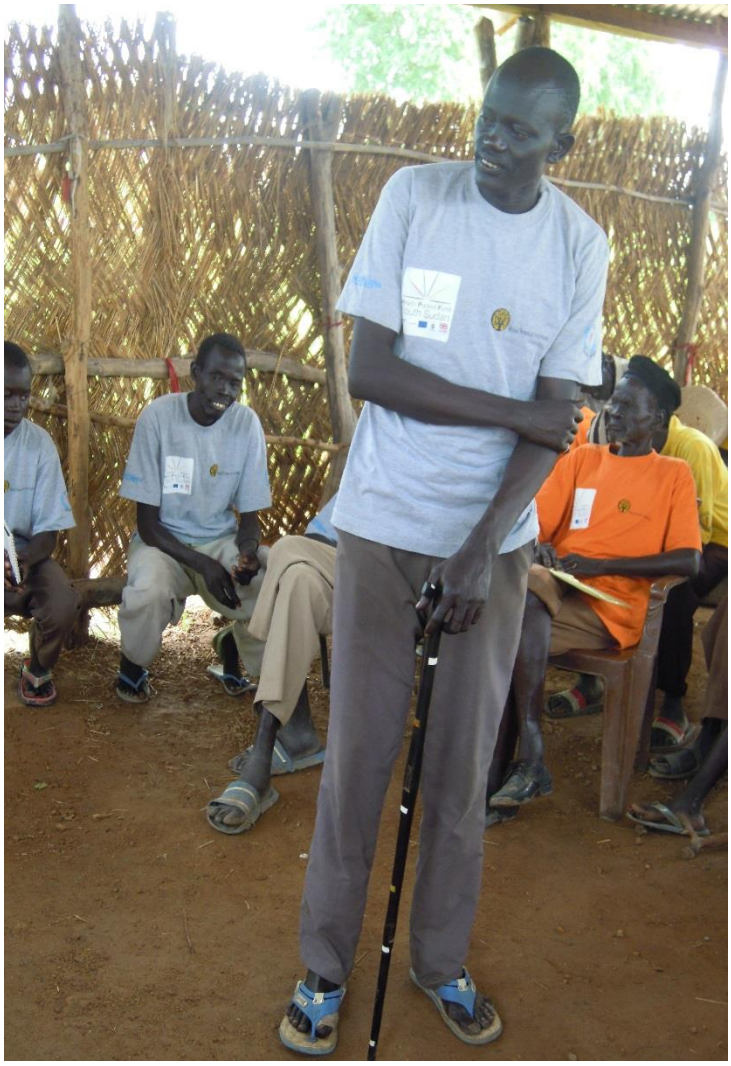
Some chiefs were secretly supporting family planning and the use of condoms. A chief said:

We are tired of burying the young girls, it is bad when providing breastfeeding and being pregnant at the same time. Girls/women can go the TBA, to provide the education on how to use family planning.

However some chiefs would oppose to family planning for girls in public. They feared when something happened, that the community would come after them.

Chiefs were in favour of the community dialogues. One chief explained that the community dialogues relieved him from having to solve teenage pregnancy related issues, it made his tasks easier. They also

recommended that they wanted the programme to be extended and be available for other hard-to-reach communities.



The Chief of the Riang'anei IDP community

2.11 Health service providers

During the baseline sessions, a variety of reasons were given why women did not deliver at health facilities. One of the reasons expressed was the attitude of midwives and nurses.

[Baseline] Man: *Sometimes a woman might not go for check-up because she doesn't know the importance of check-up, this is one, secondly, they may fail to go to the health centre because other nurses in the health centre sneer and scold at them. That is why they don't want to go there.*

[Baseline] Woman: *When you are in labour and then you hurry to the hospital, then the nurse would tell you that you should have waited till the baby is about to be delivered, sometimes when you are in labour. The nurse would not tell you something nice like let God bless you and solve your problem in peace. There are other nurses who say 'don't cry' and shout at us, when you were doing it, wasn't it suitable to you? [having sexual intercourse] Sometimes you may get a nurse beating somebody during delivery. She might tell you to shut up, this is what is happening.*

Partly because of a lack of health facilities and midwives, women used to deliver their babies at home. TBAs would support the women during delivery. Some women preferred to deliver at home for fear of cuts (episiotomy) and the fact that they are attended by male midwives. TBAs strongly believed in the traditional causes of obstructed labour or bleeding and addressed these also often by traditional practices and medicines.

Woman: *TBAs know those women who had previous retained placenta during delivery. So they would be called and upon arrival, clap three times and hit her foot hard on the ground, then the placenta comes out. If it still refuses to come out the TBA tries to pull it using her experience till it comes out. At times they are very difficult and it takes time to remove and a woman dies in the process, or the placenta comes out but she continues to bleed.*

In Gowrayen, the community indicated that they mainly delivered with the assistance of TBAs. The reason for this was that they do not have access to hospitals, and they believe that the TBAs have more experience in deliveries than midwives at health facilities. When there were severe situations, the women were brought to the hospital, but often died on the way, because the hospital was too far.

I: *How do women deliver in your community? Who assists them when they need to deliver?*
Man: *Most of the women deliver assisted by TBAs as there are no hospitals and we believe that TBAs have more experience since they are the ones who conducted our deliveries. In the worst case scenario we send our women to deliver in the health facilities, but they are too far and they end up dying on the way. Also in the health facilities our women report that they are attended by male midwives and we don't want our women to be delivered by other men and they end up cutting our women.*

The chiefs also indicated that in the past, women feared to visit the health facility for maternal health issues, because of the male midwife. Therefore some communities rather have the delivery taking place at home. Nowadays the male midwives are still around, but there seems to be less fear. However, TBAs are still regarded as the most experienced in matters with childbirth and they signal to the family when a delivery is deemed difficult.

Although TBAs were favoured above midwives, during the dialogue sessions, participants - including TBAs - strongly acknowledged that danger signs cannot be handled by the TBAs, but should be dealt with by nurses, midwives and doctors at the health facilities. TBAs would only conduct deliveries in an emergency situation to save the life of the pregnant women, with the warning that if TBAs would cause death by continuing with home delivery they would be sued to court.

Some TBAs felt threatened, and a need was expressed to strengthen the collaboration between professional health workers and the TBAs, instead of pushing TBAs, since services are often far away, skilled staff is not 24 hours available and midwives often are fairly young in relation to the TBAs. It was advised for health facilities to work with TBAs when training midwives. Also midwives can learn what TBAs are doing to make the pregnant girl more comfortable. When complications occur, the midwives and nurses can step in, if the TBA is not familiar with the difficulties faced.

Health facility staff often have similar cultural beliefs as the communities, because they are part of these communities. With regard to adolescent sexual health, many believed that making contraceptives available for young people should not happen, although they have been trained in family planning and adolescent and youth friendly SRH services, including counselling. Some felt reserved and did not want to provide these services to youth. They could provide condoms to boys, but not to girls. Also married women could be refused to access contraceptives, when not accompanied by their husbands.

Besides the prevailing social norms that are against the use of contraceptives and family planning, some health workers were also reluctant to provide contraceptives due to the risk of violence (when the husband is not aware of the use), as indicated above.

2.12 Community participation officers

The CPOs played an important role in the facilitation of the community dialogues. To be able to sustain the community dialogues, CPOs were trained in facilitating community dialogues and in strengthening facilitations skills of community facilitators. The aim of the trainings was that at the end of the dialogue sessions, community facilitators would be able to facilitate dialogue sessions themselves. This was to ensure that vital discussions that have implications for the community would continue.

For many CPOs and community facilitators the dialogues were a new way of working. This resulted in a situation in which CPOs were leading the facilitation of dialogues during batch 1 and batch 2. As they gained experience, for the later batches, they were supported to capacitate the community facilitators in the facilitation job. They became more conscious about their own role in strengthening the community facilitators' capacities.

A challenge faced during the facilitation of the community dialogues was that facilitation of the CPOs was still perceived as "teaching". This was confirmed by several statements of the participants who regularly referred to "health education meetings" instead of health "dialogues". Therefore throughout the implementation of the programme it was important for the CPOs to get a full understanding of what it means to facilitate community dialogues, for them to move away from the idea that they will teach the communities and tell them what to do and not to do.

Furthermore, a lot of issues arose during the community dialogues. Part of these gaps and problems in accessing the services are in the hands of the communities themselves, the issues that are beyond the control of the community required communication from the CPOs to the NGOs and health providers to improve service delivery. For instance, in some villages no health facilities were available. Community members together with the CPOs pleaded towards the government to provide for health services in their villages.

3. Impact

Through the information gathered during the implementation of the programme and at the end of the intergenerational community dialogues, we can conclude that the community dialogues have been appreciated by the community members, especially with regard to aiming for improved maternal health of women and girls. During end-line FGDs, changes around improved maternal health were mostly emphasized. Women were said to go to the health facilities, they deliver at the health facilities and attend ANC. Men were reported to be more understanding and supportive to their wives. The changes that have been proposed are modifications that are not going against prevailing norms in society, and would therefore be easier to apply and sustain. The more controversial issues, (e.g. family planning and youth SRH services) have been addressed in the pledges, but in the end-line FGDs, mostly only birth spacing was emphasized. Since the end-line discussions occurred only in NBeG, we can conclude that in the rural pastoralist communities the acceptance of contraceptive use before marriage was still low after the programme. Condom use was more accepted than other contraceptives. In WBeG, contraceptive use by girls and boys was more accepted, when they are involved in sexual relationships. Accessibility of contraceptives for young people was stronger emphasized in the pledges and actions to be taken at community level in WBeG than in NBeG.

The community dialogues have contributed to actions that strengthen the position of women, girls and boys with regard to their SRH and stress the importance of the involvement of men in realizing their SRH. Whether the uptake of services has increased is hard to say. There is no accurate data on the utilization of services in the health facilities and hospitals that are coupled to the exact villages where clients come from. Although there have been attempts by KIT, Health Net TPO and IMC to collect data from the health information system, this information was not accurate enough to include as evidence. Only in one area in NBeG, a small raise in ANC and family planning use was observed for several months in a health centre close to one of the villages participating in the programme, but the raise was not sustained. It was not clear whether the raise was a direct result of the community dialogues. Furthermore in NBeG, during an attempt to collect quantitative data on service utilization, it was found that family planning registers were not filled in correctly, with the reason that women did not want to be registered, or health workers themselves were afraid to register clients. Other limitations were that no end-line data was collected in WBeG, due to the security situation. Finally, during the community review meetings, end-line FGDs and interviews, it could have been that participants provided socially desirable answers. Since we have not been able to measure change with regard to the uptake of services, the mentioned changes by the community dialogue participants need to be considered with care.

4. Sustainability

To improve responsiveness of services and to make sustainable improvements for maternal health, the engagement of VHCs during community dialogues needs to be reinforced. This could improve and support community advocacy activities for addressing problems and demands that emerged during the dialogue sessions at facility and county level. For example, issues like fees being asked during delivery, lack of transport, equipment and the non-availability of ambulances, when ambulances are being used by senior policy makers, could be addressed via well-functioning VHCs.

There is need for more initiatives to sensitize communities to own health initiatives to make them sustainable. A possible way would be to initiate continuous communication at the interface between health service providers, county and *Payam* level authorities and communities. The health providers could receive a larger role during the public meeting, including in the follow-up of the programme.

There is also need to consider training to stimulate attitude change of health facility staff and people in authority regarding SRH issues, because cultural beliefs and practices are deeply entrenched and remain a negative influence to acceptance of SRH services such as contraceptives, especially if supported by people seen as role models.

5. Conclusions and recommendations

From community members' feedback it can be concluded that the community dialogues have partly covered the objectives of the SHARP community participation programme.

First of all, the programme has contributed to an improved health-seeking behaviour of the community with regard to maternal health care services, including the use of family planning. Elders also have a better understanding of the issues that girls and boys are struggling with. Knowledge has increased about the negative consequences of child marriages and teenage pregnancies, and actions have been taken to increase the accessibility of SRH services for young people.

Furthermore, the objective to increase capacity of communities to fulfil their roles and responsibilities in achieving SRHR has been reached. Through the community dialogues, communities became more knowledgeable about harmful practices that have negative implications for pregnant women and girls. With the knowledge gained, participants were open to adjust these harmful practices. Therefore they jointly took action to prevent maternal death, by supporting pregnant women to go for antenatal and postnatal care, and delivery at the health facilities, by saving money for emergency situations, by using family planning methods and spacing children, and by making condoms and contraceptives better accessible for young people. Some communities saw the importance of delaying marriages of girls. Unfortunately, we have not been able to measure on what scale these changes occurred.

A critical note can be brought up around bride price practices. The bride price practice strongly contributes to men having decision making power over the family, especially in relation to the SRH of women and girls. Through bride price practices women and girls are seen as a property and carry child bearing as their main duty in marriage. The practice itself enforces large families at the cost of women's and girls' decision making power around child spacing and family planning. During the dialogues, bride price practices were not seen as a contributing factor that obstruct the SRH of girls and women; and possibly resulting in conflict. The main observations especially from participants from Wau county was the bride price being too high, which creates difficulties for men to marry women. A reduction of bride price is a first step that could result in couples having more liberty to choose their spouses. This reduction of price could also lead to a less significant emphasis of girls and women being a form of property for reproductive purposes. To enhance SRH, in future community dialogues it will be important to discuss the implications that bride price practices have for SRH of girls and women and the overall wellbeing and relationships within families.

With regard to the access and quality of care, it is not clear how the collaboration of community members with health workers has improved and how constraints have been addressed. Health workers - except for TBAs who are not professional health workers - had no specific role during the community gatherings and community dialogues. Some community dialogue participants expressed the maltreatment of health providers during delivery, but no direct follow up actions were mentioned towards health workers in their action plan. As mentioned above, some VHC participants did engage in the community dialogues, but no references were made during the consultations with respect to their role. Therefore it is hard to say if the collaboration between health workers and communities has improved. This is a point of attention to better take into account in future community dialogue activities. It would be recommended to engage (community) health workers during public meetings, for them to support the actions that need to be taken to improve SRHR issues, but also to engage them during session 3 about danger signs.

It is clear that the community dialogues contributed towards improved communication, improved health knowledge and creating an environment where community members are more in charge of their own SRH. However, social norms, beliefs and preferences still have an influence on the health

seeking behaviour of women, men, boys and girls in the communities. Therefore the biggest challenge remains with the sustainability of these efforts. Changes can have a deeper impact when a critical mass has been created who is capable to adjust the harmful beliefs, norms and practices. To be able to have this critical mass, the community dialogue process needs follow-up at different levels in society, between communities, the health and women's department, *Payam* administration and health facilities, to allow for ongoing reflection on emerging issues. This would assist in initiating an ongoing process of social transformation.