Perceived healthcare needs and access to healthcare. An anthropological assessment in the Greater Pibor Administrative Area, South Sudan

Medication is like food*
Author’s note

I would like to thank the research participants in the Greater Pibor Administrative Area (GPAA) who contributed to this assessment, trusted me and my assistants, and shared their personal experiences regarding health needs and access to healthcare, which led to the results, arguments and recommendations made in this report.

A researcher cannot make immediate impact, but I hope that the information I have gathered and the conclusions drawn will enable MSF to strengthen the project proposal, creating successful dialogue and cooperation with communities and healthcare providers to respond in an appropriate and feasible way to the tremendous health needs in the area.

My gratitude goes to the assessment team, to the MSF coordination in Juba and headquarters in Brussels for their valuable support. I particularly want to thank the South Sudanese and international colleagues who worked with me for their professional attitude, in-depth knowledge of the country and its people, and our enlightening discussions.

My experiences with MSF, my colleagues and the people in the GPAA are precious to me; they all have my respect for their ability to cope with the difficult living conditions and their limited access to healthcare.

This is for all those who will be part of the new project in South Sudan.

Doris Burtscher
doris.burtscher@vienna.msf.org, doris.burtscher@gmail.com
Support: John Kaka, Barbour Chacha, Alyssia Ferrarese, André Moret, Livia Tampenilli, Jesse Verschuere
Study managed by the Vienna Evaluation Unit/Anthropology, OCB and Juba coordination, South Sudan
Vienna/Brussels/Juba 2021

*Quote from a community leader when we were discussing access to healthcare.

Cover picture: woman carrying a 20L jerrycan from the waterpoint to her home.
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<tr>
<td>ACF</td>
<td>Action Contre la Faim</td>
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<tr>
<td>ACROSS</td>
<td>Transforming Lives &amp; Communities NGO</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>CHD</td>
<td>County health department</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>GI</td>
<td>Group interview</td>
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<td>GPAA</td>
<td>Greater Pibor Administrative Area</td>
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<td>HDC</td>
<td>Health development committee</td>
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<td>HP</td>
<td>Health Promotion</td>
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<td>iCCM</td>
<td>Integrated community case management</td>
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<td>IDI</td>
<td>In-depth interview</td>
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<td>JAM</td>
<td>Joint Aid Management</td>
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<td>MAM</td>
<td>Moderate acute malnutrition</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NTD</td>
<td>Neglected tropical diseases</td>
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<td>OCB</td>
<td>Operational Centre Brussels</td>
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<td>PHCC</td>
<td>Primary healthcare clinic</td>
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<td>PHCU</td>
<td>Primary healthcare unit</td>
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<td>PI</td>
<td>Primary investigator</td>
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<tr>
<td>PNC</td>
<td>Postnatal care</td>
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<tr>
<td>RTI</td>
<td>Respiratory tract infections</td>
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<tr>
<td>SAM</td>
<td>Severe acute malnutrition</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>SMOH</td>
<td>State Ministries of Health</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<tr>
<td>TCAM</td>
<td>Traditional, complementary and alternative medicine</td>
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<tr>
<td>TH</td>
<td>Traditional healer</td>
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<tr>
<td>VSF</td>
<td>Vétérinaires Sans Frontières</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

Background

After 15 years of presence, and providing mostly primary and secondary healthcare to the population (the majority are cattle-keeping Murle and a smaller number of Anuak, Jiye and Kachipo) living in the Greater Pibor Administrative Area (GPAA), MSF decided to end the Pibor medical activities at the end of 2020. The changing context in and around Pibor complicated MSF’s operational efforts to actively respond to the population’s needs. Constant security problems and natural disasters, like repeated flooding, obliged MSF to take the decision to depart from Pibor.

From January to March 2021, an in-depth assessment was conducted in Boma county to define where the project would work from, the scope of the activities and the medical strategy that should be endorsed by such a future project.

The aim of the medical anthropological assessment was to generate an in-depth understanding of how Murle and Jiye perceive their own health/illness/disease and what the main persons/factors/elements that influence their health-seeking behaviours are. What are the available options in terms of access to healthcare and traditional, complementary and alternative medicine (TCAM), and what are their coping mechanisms and strategies?

Healthcare situation in Boma county

In Boma county, primary healthcare services are provided through:

- One PHCC located in Itty/Boma covering the whole county population. The Boma PHCC is considered the referral centre for healthcare.
- Three PHCUs located in three different payams: Naoyapuru, Labarab and Mewun (not visited).

In Boma county, access to healthcare is poor and in some remote and isolated places non-existent. This is due to 1) lack of healthcare facilities and 2) challenging geographical accessibility.

Methods

The study was based on qualitative research techniques. Forty interviews in total were conducted between 5 and 26 February 2021. We spoke to a total of 108 people. Written notes were taken for all interviews, translated and transcribed directly into English. Transcriptions were screened for relevant information, manually and with NVivo 11 coded, and analysed using qualitative content analysis methods. An extended literature review prior and after the field visit, as well as discussions with the assessment team, the coordination team in Juba and key people in MSF’s headquarters in Brussels, further helped to validate the findings and formulate recommendations.

Overview of findings

This report provides an analysis of the main healthcare needs and current access to healthcare of the population in the GPAA. The results section summarises their main health problems, how people experience and navigate their health-seeking behaviours and explore the scarce and unsatisfactory healthcare choices available to them, what alternative healthcare options exist, what the practices of traditional, complementary and alternative healthcare providers are, when, how and for what ill-health conditions they
are consulted, and finally, what factors influence where people seek care. The main factor influencing health-seeking behaviour is the availability of healthcare facilities per se.

The lowland and highland Murle
The Murle have two distinct lifestyles and there is cultural diversification – the lowland or pastoralist Murle and the highland or agriculturalist Murle – however, they do consider themselves as one people. The primary difference between the highland Murle and lowland Murle is their means of livelihood. The lowland Murle herd cattle and other animals. Everything is organised around the cattle, including most of the social activities. For the Murle, being wealthy means owning as many cows and bulls as possible. Not having any cattle means poverty. Within the society, cattle are used as a form of money to make loans, to pay the dowry, to exchange for other goods, and more. Cattle raids are extremely important, both for the acquisition of new cattle and for proving the virtue of young men.

In Murle society, age-set systems are well-defined groups of men based on age, which accompany them through life, although these age-sets are most important in youth when young men are searching for wives, and have a responsibility to protect the community (Felix da Costa, 2013). One main difference between the highland and lowland Murle is reflected in the age-set system. Lowland Murle join their age-set according to their age, the highland Murle join the age-set according to interest.

The Jiye

The word “Jiye” means combatant. The Jiye are an agro-pastoral community; the core of the Jiye habitat is situated in the vicinity of the Kassangor Hills, on the border between Kapoeta and Boma. The Jiye population count less than eight thousand, which makes them one of the smallest groups in this part of South Sudan. It is a particularly resilient society, which, over the two centuries of its existence, has survived periods of extreme drought and famine, severe cattle diseases and periods of devastating raids by their more powerful neighbours, the Toposa.

Like the Murle, the male Jiye population is organised around a variety of generation and age-sets. An age-set system incorporates males of approximately the same biological age for the purpose of advancing them up a series of distinct societal levels, each of which requires them to perform certain duties and to follow certain behavioural norms. Intercommunal violence among the Jiye in Kassangor was observed and it was also frequently reported in the interviews. Women who walked by while interviews were being conducted showed the wounds on their bodies. We suspect that this intracommunal violence is mainly due to the high consumption of alcohol, with other secondary reasons also contributing.

General ill-health conditions and main healthcare needs

Disease causation
In general, every disease is related to God, but people can avoid getting sick by complying with behavioural, social, and moral rules. Causes might be found in the natural world, like an accident or malnutrition, where the person dies as a consequence. They can also be found in the supernatural realm, where the cause is related to God or other supernatural forces, like ancestral spirits (of deceased persons) or other spirits living in the environment, like the river goddess Nyandit. If someone has failed to show respect to their ancestors, or ancestors are angry about the behaviour of living dependants, they can make a person sick. This is most
significant when people refer to traditional healers for treatment, like the ngari for Murle and amuron for Jiye, mainly in Labarab, Kassangor and Naoyapur.

Among the main ill-health conditions like fever/hot body/malaria, diarrhoea, breathing problems and chest pain, rash, etc., which we will stratify according to gender and age in the following subchapters, leaders in the different communities also mentioned outbreaks like cholera and measles.

**STIs, syphilis, gonorrhoea**

Men and women alike did talk about one main ill-health condition which was referred to as dolach in Murle and lokot in Jiye, and was translated as syphilis. Lower abdominal pain and back pain were the symptoms mentioned regularly. It was explained that it is “inside the body and that it is paining inside.” Reasons for getting syphilis were in most cases related to the lifestyle of having as many women as possible in marriage, and also outside of wedlock. Syphilis was especially mentioned in the context of impotence in men and infertility in women. Men explained that when they suffered from prolonged STIs, they were no longer able to engage in sexual intercourse with their wives, and that they feared being laughed at by their women.

**Ill-health conditions in children**

- Malaria – ‘hot body’/fever/convulsions
- Diarrhoea, watery and running stool, bloody stool and ‘chuguk’ (cracks around the anus)
- Measles, mumps, typhoid and polio
- Nutrition and malnutrition

**Sexual and reproductive health**

Women’s sexual and reproductive health is central to the continuity of a family’s lineage and therefore it is vital to have healthy women who can give birth to healthy children. It was repeatedly acknowledged that a community can only exist when families have several children, to guarantee their security, survival and succession. After cattle raiding, when women and children were also abducted or after an outbreak of cholera or other diseases, women should get pregnant again to compensate for the loss.

**Personal hygiene**

When girls get their first menstruation, elder women or the mother advise her what to do. Before the first sexual intercourse, usually it is the husband who will ‘advise’ his wife. For personal hygiene, it depends on where the women live and how feasible and easy access to water is.

In a discussion with healthcare staff in the Boma PHCC, I was told that some women deal with their personal hygiene in a different way, as deemed appropriate by educated healthcare staff. Referring to that a woman should keep her husband’s odour in her body as a sign of appreciation to him.

**Pregnancy and childbirth**

The mothers and elderly women tell the younger women what to consider during pregnancy. Apart from physical and nutritional aspects, behavioural and moral rules are imposed on the women.

Rules and regulations during pregnancy:

- Not staying in direct sunlight, as the heat could reach the child and cause miscarriage
- Not carrying heavy things, as the body’s blood could go downwards and push the child out
- Not eating the uncut intestines of a cow, as this could cause the placenta not to come out
- Not sitting on a stone because delivery might take a long time and, since the stone is hard, it could push on the child’s head as the child turns downwards in the fifth or sixth month of pregnancy, or the woman could fall from the stone and hurt the child in her womb
- Not bending to one side while a woman sits as the umbilical cord could wrap around the child and the child will have difficulties coming out
- Not bending down as the placenta would move towards the foetus and block the breathing system of the child
- A pregnant woman should sit upright so that the umbilical cord does not wrap around the child’s neck
- A pregnant woman should not sleep on her back or on the belly but rather, on her side to prevent the umbilical cord wrapping around the child’s neck
- Not sitting on the wrapped cloth women use to carry heavy loads or water on their heads as the placenta could get stuck in the womb
- Sexual intercourse is forbidden after the sixth month
- After childbirth, Jiye women have to stay ‘indoors’ for one month the Murle some days, and should not take the child outside to protect both her and the child from ill-health

Three main problems were mentioned consistently as occurring during pregnancy:
- Miscarriage
- Prolonged labour, up to 1-2 days, leading to the death of the child and sometimes the mother as well
- Discovering during labour that the child is in a wrong position which could lead to the death of the mother, the baby or both

Most deliveries take place at home with the help of elder or experienced women or a TBA. In most cases, several women attend, but only three interfere directly with the woman in labour. Usually, women deliver in a squatting position with the women supporting them both in front and behind. The Jiye explained that the woman holds a trunk while giving birth.

**The significance and importance of having many children**

For the Murle the only really dead person is the one who dies without children. Any dead person is only physically dead, but the spirit remains and becomes an ancestor who cares for subsequent generations of relatives. The question of infertility is a vital concern, for which ‘creative’ solutions are found in both the Jiye and Murle communities. The most important objective of such solutions is that a person’s lineage does not end with the death of the person, and that no-one should die without children. In the Jiye populations, an infertile woman is given children by other wives of the husband, whereas among the Murle, the husband might marry another woman who bears children in the name of the infertile woman and the children born are considered hers. If the man is infertile, he might ask his brother to sleep with his wife, or, if his wife is very young, he may ask his oldest son to have sexual intercourse with her. The children are considered to be the father’s children and to continue his lineage. Others said that a man may ask his wife to find a solution ‘outside’ in secret, meaning she should look for a lover, and the children born are considered her husband’s.

**Meaning and perception of death**

For both the Murle and Jiye a dead person is not considered dead and therefore death is not announced in the community. A dead person becomes an ancestor with whom people stay in touch throughout their lives.
Death is considered an impure matter that can harm the living. This is why people who have been in touch with dead bodies, or persons who have killed somebody have to undergo some purification.

Healthcare options in the GPAA

Traditional versus formal approaches to sickness and healing

The main difference between traditional and formal approaches to sickness and healing lies in the perceived cause of a health problem: Formal medicine concentrates on the human body while traditional medicine concentrates on forces outside the human person, which came to disturb their physical well-being.

Available healthcare options:

- **PHCC** in Boma (supported by CARE)
- **Private clinic** at Boma market, not really mentioned as a viable option
- **PHCU** in Labarab and Naoyapuru (Labarab not functional)
- **Community health workers (CHWs)** – no formally trained and appointed CHWs were met;
- **Traditional birth attendants (TBAs)** – TBAs were said to be almost nonexistent if a TBA is understood to be a woman experienced in helping women in childbirth, who has received some training from the MoH or from NGOs
- **Traditional healers (TH)** – include those who perform divination or rituals and treat the person through spiritual and performative means and those who join broken bones and apply herbal treatment.

Apart from these options, and only when an ill-health condition is considered very serious and only during the dry season, people travel to Kapoeta to a second-line hospital, or alternatively, they go ‘outside’, meaning travel to Ethiopia to access healthcare there.

Health-seeking behaviours

As with many other contexts, the decision of where to go for treatment is not an individual decision. In most cases, it is taken either by the family or by the husband of the woman who is sick, or whose child is sick. What can generally be acknowledged for all places visited and both ethnic groups is the differentiation between diseases that should be treated in a healthcare facility and disease that can be treated with a traditional healer only.

The value of a sick person

In contrast to many other social contexts in Sub-Saharan Africa, in this area of South Sudan, a sick child is valued more than a sick adult. It was explained that a child needs to get cured in order to become an adult, so as to be able to give birth to many children; an adult has already delivered children and can go (die).

Popular knowledge about herbal treatments and self-treatment at home

Alongside the specialist knowledge which traditional healers have acquired throughout their lifetime, there is vast popular knowledge of various medicinal plants for different ill-health conditions. For lack of other options people do fall back on their own herbal knowledge a lot and they collect and fetch herbs to treat their ailments.
Plants are used in the form of leaves, barks and roots and either pounded to powder, burnt to ashes or made into a decoction to drink. Sometimes, plant powders are directly applied to the wound or mixed with water and then drunk.

**Traditional healers and TBAs**

Different types of traditional healers are available and the belief in the effectiveness and efficiency of their practices differs considerably. Traditional healers are consulted when people think a supernatural force is involved in the illness, like curses or non-compliance with a taboo. In Boma and Maruwo, the traditional healer does not play an important role anymore. People consult traditional healers mainly for non-natural ill-health conditions, which could be swellings, paralysis, etc.

In Kassangor, people explained that they first tried to find out what has caused the ill-health condition and therefore went to the traditional healer, especially to find out if witchcraft is involved or not. Answers in Kassangor were a bit mixed and at times a bit confusing as well, as some said the first option is the atalya = Western healthcare facility, while others said that first the amuron had to ‘check’ if witchcraft was involved. If it is not, then the disease needs to be treated by the Western healthcare facility. People living in cattle camps access healthcare through traditional healers and self-treatment rather than seeking out a facility. When they are close to a place with a Western healthcare facility, they do draw it.

**Formal healthcare facilities – the PHCCs and PHCUs**

When talking about people’s experiences with ‘formal’, ‘Western’ or ‘professional’ healthcare facilities, we also have to address the differences that were experienced in healthcare provision at the PHCC in Boma, which people referred to in respect of the hospital being initially supported by MERLIN and subsequently by CARE. Everybody praised the ‘old times’ (2008-2013), when MERLIN was present in Boma, while they were highly critical of the performance of CARE.

People walk to Boma from Maruwo, Labarab and Kassangor, but are hesitant to engage in such a journey. Boma is an option and yet often, it is not. People can walk but it is very far, and they might arrive only to find that there is no treatment because the required medicines are not available. And they risk dying on their way to Boma, either because they are too sick or because of insecurity. People only travel in larger groups, as they fear being attacked by Murle or Toposa.

**Going ‘outside’**

People frequently mentioned ‘going outside’, meaning to go to a place outside their village and beyond South Sudan. ‘Outside’ meant to leave Boma county to get treatment in Kapoeta or in Ethiopia. Whereas Kapoeta cannot be reached during the rainy season, it was underlined that people could still walk to Ethiopia.

**The private clinic in Boma**

The private clinic that opened in the Boma market recently (in 2020) is only an option for people with money. Further, it was observed that even the private clinic sometimes ran out of drugs.

**Factors influencing health-seeking behaviours**

Health-seeking behaviour is influenced by many factors which interfere, overlap and often vary within the same family during ill-health. Given the scant healthcare system that exists in the GPAA, how do households navigate the available options, and what factors influence decisions?
Volatile and harsh living conditions are the main reasons that influence people’s access to healthcare. These are, first and foremost, the availability and accessibility of healthcare. Disease interpretation and explanatory models play only a secondary role, as traditional and complementary medicine is used when other healthcare options are simply not available, which means in most cases that people cannot chose where to go for treatment, but have to make use of what is available, and that is plants and healers.

**Access to healthcare**

Either no health facility is available or facilities are too far away, like in Boma, Kapoeta and Ethiopia, and are therefore either inaccessible or unaffordable (financial resources, means of transport, rainy season, etc.). Affordability plays a role when it comes to financial and economic aspects, including additional associated costs like travel costs and lost time.

**Illness perception and explanatory models**

How the causes of an ill-health condition are perceived determines whether the disease is treated with a traditional healer, *ngari* in Murle and *amuron* in Jiye.

**Decision-making and social values**

Therapeutic choices are generally made on a case-by-case basis. Decisions usually involve husbands, mothers-in-law, parents, relatives, or neighbours, or other authoritative people, like a village chief, a red chief, who act on behalf of the patient, especially in more serious and threatening situations. In the case of sick children, the child’s mother mainly consults with her husband or the mother-in-law.

**Medical pluralism**

Medical pluralism refers to the different types of healthcare provision that coexist in a territory and their relation to reach other. Whereas people constantly said that malaria is best treated in a formal healthcare facility, convulsions are still treated by the traditional healer, often in combination with biomedical treatment. The treatment options people refer to are self-treatment at household or community level, traditional, complementary and alternative medicine with healers and TBAs, and biomedicine in a professional healthcare facility.

**Perceived quality of services available and provided**

People return to the healthcare structure where they were successfully treated and from where they received the expected medication (quantity and type of medication). In the assessed area, access constraints outweighed the perceived effectiveness of treatment, and people were forced to fall back on services they do not deem the most effective. Perceived quality is also related to expectations to receive a certain number of drugs, specific medication they had used before, or receiving an injection rather than pills. Drug shortages in the PHCU and PHCC meant that people were referred to facilities further away, like Kapoeta or Ethiopia, or to places they could not afford, like the private clinic in Boma. Therefore, people felt that the PHCUs and PHCCs were unreliable.

**Prior experiences of different healthcare sectors**

This contributes to satisfaction or dissatisfaction and generates expectations, as well as influencing perceptions of the quality of care available. Prior experiences provide a frame of reference for the
comparison of different preventative tools and/or healthcare providers, as seen when people were comparing MERLIN with CARE.

Coping strategies

In the course of the assessment, understanding the very difficult living conditions, and associated with these, the complicated access to healthcare, we tried to evaluate how people coped with their challenging circumstances. Historically, this area has been prone to natural disasters, conflicts, cattle raiding and diseases for a long time. In this sense, family networks are vital for mutual support.

In the areas we have visited, we identified four different ways of coping. A difference was observed between the Murle and the Jiye regarding alcohol abuse.

- Love for the country
- Faith in God
- Hope derived from MSF or other NGOs
- Alcohol used as food replacement

Recommendations

Community engagement approach

Apart from medical activities, the project should promote a strong community engagement approach in order to create active participation from the side of the community, so as to encourage not only sustainability, but also stability. Therefore, a strong link with key actors, and even more so with important medical actors from the communities is paramount.

Collaborating with TBAs

Collaboration with TBAs should start with an exchange of knowledge and skills, and then move on to training with a qualified midwife to transfer skills which TBAs do lack. This training should conclude with the provision of materials, like gloves, cotton, razor blades, soap etc. Collaboration with TBAs should start with mapping all available TBAs who are interested in cooperating.

How?

- Invite TBAs to the PHCU and let them do the job with a midwife. TBAs should be considered partners and not ‘persons who are used only to refer pregnant woman’; they should participate in the actual childbirths at the PHCU.
- Let women choose whether they want to deliver in a squatting position or on a bed or chair.
- Let them choose if they prefer to deliver in a tukul specially prepared for delivery in a squatting position, or on a bed or chair in a room within the PHCU.
- Let them decide if they want the delivery to be attended by the midwife or the TBAs, or by both.

Be prepared that a delivery is attended not by one TBA, but by at least two or three! So, we have to question whether we ready for that.
Why?

- Because the TBA will still be there and will do the job after MSF leaves
- To be more sustainable for a handover to another NGO or MoH
- During conflict and natural disaster, they are the only available resource
- For sustainability and knowledge transfer

Integrate traditional healers

The collaboration and integration of traditional healers may only be relevant in certain areas, as in Maruwo and Boma, people did not trust traditional treatments anymore. However, traditional treatment rituals are still ongoing on a regular basis in Labarab and Kassangor. MSF could facilitate a mapping of those healers who are still active in treatment and ritual performances, and who would be interested in collaborating with us. By organising a dialogue workshop, MSF could foster a discussion that compares traditional perceptions and ideas around witchcraft with biomedical perspectives related to diseases, pregnancy, labour and childbirth. Such a workshop could help healthcare providers gain a more concrete understanding of previous health-seeking behaviours.

Implement integrated community case management (iCCM)

Communities (for example in Boma) are not satisfied with the quality of services provided in the formal healthcare system (CARE), and due to the lack of access to healthcare, they are forced to rely on self-treatment and alternative healthcare providers.

One very important aspect is to find out if we need to consider the age-set organisation of men in order to find out which person would be the best fit for which age-set group. Do we also need to consider the age-set affiliation of the CHWs?

Conclusion

This assessment was conducted to map the population’s needs respecting and access to healthcare, factors influencing health-seeking behaviours, and the coping strategies developed to compensate for the absence of any formal healthcare provision.

People’s treatment path first involves herbal self-treatment at household level, before navigating other available options, which are often nothing more than a small PHCU, a traditional healer or somewhere ‘outside’ their place of residence, which includes travelling (walking) to Kapoeta or Ethiopia. The PHCC in Boma is not an option considered as part of the health-seeking path because of a lack of equipment, materials and services, the interrupted drugs supply, insufficient human resources and a lack of trust towards the facility as a whole.

The local people have shown a high level of resilience, but they cannot solve the inadequate healthcare situation on their own. Dependence on the support of NGOs seems to be a precondition to improve access to healthcare. MSF is needed to assist both people in the GPAA and the formal health sector in providing accessible healthcare options to cope with their ailments. In that sense, ‘food’ is needed for survival because “medication is like food”.

14
1 Introduction

1.1 General Context

After 15 years of presence, and providing mostly primary and secondary healthcare to the population (the majority are cattle-keeping Murle and a smaller number of Anuak, Jiye\(^2\) and Kachipo) living in the Greater Pibor Administrative Area (GPAA), MSF decided to end the Pibor medical activities at the end of 2020. The changing context in and around Pibor complicated MSF’s operational efforts to actively respond to the population’s needs. Constant security problems and natural disasters, like repeated flooding, obliged MSF to take the decision to depart from Pibor.

The observations and discussions of this report reflect the local population’s coping strategies: they are escaping these disruptive constraints by moving slowly towards the south-eastern part of this autonomous administrative area. This coping mechanism may be encouraged by a wider economic / political agenda from the local administrative authorities, with a long-term objective to have some populations from greater Pibor moving south-east, freeing space (and facilitating security enforcement) to allow exploitation of the natural resources available around Pibor.

In order to be able to continue supporting ‘Murleland’ and the other various ethnic groups residing in the area, MSF intends to continue to provide quality healthcare for these populations.

Early in 2020, an initial assessment was done in Boma county and Pochalla to identify the population’s medical needs and the current response, along with the technical feasibility of implementing future activities.

From January to March 2021, an in-depth assessment was conducted in Boma county to define where the project would work from, the scope of the activities and the medical strategy that should be endorsed by such a future project.

Assessment parameters

1. Study site: Greater Pibor Administrative area (GPAA)
2. Period: January 2021 – March 2021
3. Methodology: qualitative research techniques
4. Assessment team: field coordinator, project medical referent, log manager and anthropologist
5. Support from local professionals, like drivers, translators and medical staff from mobile clinics

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\(^1\) This section is a compilation of parts taken from previous assessment documents, TOR and the CoPro; their inclusion is intended to serve a better understanding of the context and an independent reading of the anthropological report.

\(^2\) There are two ways of spelling, Jie and Jiye. In the literature it was found that Jie is used for the Jie living in Uganda and Jiye for the Jiye living in South Sudan.
The areas visited by the assessment team previous to the arrival of the anthropologist included Boma/Itty town, Upper Boma (on the hill, 4-6hrs when walking up and 2.5hrs when walking down to Boma), Nyat (2.5hrs walk from Boma), Naoyapuru (45mins walk from Boma), Maruwo (11hrs walking, 3-3.5hrs driving), Labarab (3 days walking, 9hrs driving through Maruwo) and Kassangor (14hrs walking, 4hrs driving). Driving is only possible during the dry season, which means that rare, occasional transport opportunities are only available to the population during the dry season, from December to June.

The anthropologist visited and worked in Boma, Maruwo, Labarab, Nyat, Naoyapuru and Kassangor.
1.2 Healthcare situation in South Sudan

South Sudan has an estimated 11 million people (in 2018) and has some of the worst health outcome indicators globally. This is mainly due to complex emergencies resulting from prolonged conflict, climate change, a weak health system and frequent outbreaks of communicable diseases. Growing demand for health services and limited resources affects the development of the health system. Maternal mortality rate and mortality rate of children under five years are 789 per 100,000 and 95 per 1,000 live births, respectively. Communicable diseases constitute a significant public health problem. While neglected tropical diseases (NTDs) are endemic, non-communicable diseases, notably mental disorders, are on the rise. Inadequate infrastructure, such as the lack of an adequate road network and mobile phone services, coupled with security issues hinders the outreach in the country. On top of its multiple humanitarian emergencies, South Sudan has to contend with a chronic public health crisis affecting the majority of the population, which also lacks access to clean water. There is a persistent shortage of health professionals at all levels, from nurses and midwives to lab technicians, doctors and surgeons (1 physician/65 574 people). The human capacity deficit also extends to the planning, policy, and supervision functions of the health system. Sufficiently qualified staff are almost entirely absent from the County Health Departments (CHDs), and the situation is little better at either the State Ministries of Health (SMOH) or at the national Ministry of Health (MOH). Planning capacity is particularly weak, meaning that predictable seasonal outbreaks of diseases like malaria rapidly turn into full-blown health crises because stockpiles of drugs and mosquito nets are not ordered and distributed in advance. In the GPAA, most of the health indicators are unknown but the lack of a functioning MOH in the whole GPAA is a clear indicator that the health situation is worse there than in most of the rest of the country. The GPAA population’s healthcare relies entirely on NGOs. A large part of the population falls back on herbal self-treatment and traditional healers, necessitated by a lack of healthcare facilities and professionals.

1.3 Healthcare situation in Boma county

In Boma county, primary healthcare services are provided through:

- One PHCC located in Itty/Boma covering the whole county population. The Boma PHCC is considered the referral centre for healthcare.
- Three PHCUs located in three different payams: Naoyapuru, Labarab and Mewun (not visited).

Access to healthcare

In Boma county, access to healthcare is poor and in some remote and isolated places non-existent. This is due to 1) lack of healthcare facilities and 2) challenging geographical accessibility.

1. Lack of healthcare facilities:

The total number of healthcare facilities (all currently supported by CARE international) existing in Boma county are insufficient to respond to the needs of the catchment population and to cover the whole area efficiently:

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3 Administrative divisions are still unclear.

4 In South Sudan, a payam is the second-lowest administrative division, below counties. Payams are required to have a minimum population of 25,000.
• The expected catchment population for a PHCC is supposed to be 50,000 people. In Boma county, there is only one PHCC for an average of 200,000 inhabitants.

• A PHCU is expected to provide a basic first level of care for about 15,000 people. In Boma county, the Labarab’s PHCU\textsuperscript{5} is covering a population of almost 55,000 inhabitants and is not functioning most of the time (closed because of drug shortages > 6 months a year.)

2. Extremely challenging geographical accessibility:

The population in Boma county is widespread over a vast territory, where people living in remote and isolated places face an eleven-hour to three-day walking distance to reach the PHCC in Boma or any PHCU. If the dry season is challenging, the rainy season is even more difficult as it makes walking trips arduous and sometimes not feasible, while driving journeys are impossible.

In addition, the second-line hospital in Kapoeta is only accessible during the dry season (12hrs driving from Boma PHCC). During rainy season, referrals are impracticable (unusable roads).

\textsuperscript{5} At the time of the assessment in Labarab (12-16 February 2021), the PHCU was not functioning. The Tukul was empty and no drugs were available.
2 Objectives

2.1 General objective

Inform the discussion about a future project through a deepened understanding of health care perception and needs, health-seeking behaviour, different healthcare providers (including traditional, complementary and alternative medicine, TCAM), and perceived and experienced barriers to accessing healthcare among the different communities in the GPAA. Based on the anthropological findings and analysis, the anthropologist will help to adapt medical activities to the context.

2.2 Specific objectives

- Examine the main health-related needs of the various population groups – men, women (incl. pregnant and lactating), children, adolescents, etc. Health needs in relation to different life events, such as rites of passage or ritual fighting and gunshots related to this, i.e., needs that might be different at different times of life
- Understand local perceptions of health and illness (in relation also to lifestyle, mobility, cattle or agriculture etc.)
- Understand people’s perceptions and experience of available healthcare facilities in relation to their medical needs
- Analyse people’s experience and perception of medical care and their satisfaction with treatments from different healthcare sectors, including alternative healthcare providers
- Explore factors influencing health-seeking behaviour, decision-making, access constraints, influential factors, treatment preferences, self-treatment, etc.; which services are used for what
- Understand different types of alternative healthcare provision, which sector is accessed for what
- Look at the influence of lifestyle on people’s health (symbolism of cows...)
- Explore how health is impacted by environmental change (e.g., increased floods) and intercommunal violence
- Actively share and discuss findings with the operational team (assessment team, coordination, cell). Use different ways of distribution
- Together with the operational team, translate findings into operational recommendations for the future project strategy

2.3 Aim of the assessment

The aim of this assessment was to generate an in-depth understanding of how Murle and other ethnic groups perceive their own health/illness/disease and what the main persons/factors/elements that influence their health-seeking behaviours are. What are the available options in terms of access to healthcare and traditional, complementary and alternative medicine (TCAM), and what are their coping mechanisms and strategies?
3 Methods

3.1 Assessment design

A qualitative research design was used to gain multiple perspectives (selected communities with their members, as well as healthcare staff, community health workers (CHW), traditional healers, TBAs and local leaders) on perceived healthcare needs and experiences with health-seeking behaviours, and the various factors influencing it (Pope & Mays, 2006). The methods used for data collection were in-depth interviews, paired (two individuals) and group interviews (GI) and observations. Validity of data was enhanced through triangulation: data from in-depth individual interviews were combined with group interviews and document reviews to corroborate information from these different sources (Green & Thorogood, 2018; Patton, 2002).

3.2 Assessment setting and study population

The study was conducted in the Greater Pibor Administrative Area (Fig. 1) with the various locations visited as indicated above and shown in Fig. 4.

The study population was composed of different groups of respondents. It included both genders and diverse personal and professional backgrounds, ages, levels of education, ethnical affiliations, and social disparities. The general populations in the different study sites approached for data collection included traditional healers and TBAs, healthcare professionals (MoH and NGOs), community health workers and community leaders, and local authorities.

Forty interviews\(^6\) in total were conducted: ten in Boma, twelve in Maruwo, six in Labarab, three in Nyat, two in Naoyapuru and six in Kassangor between 5 and 26 February 2021. The anthropologist went with the assessment team to different locations where mobile clinics were planned; during the stays in these locations, interviews were conducted in the communities. The mismatch of the numbers of interviews conducted in the different locations corresponds to the time the team and the anthropologist spent in each location. Two places, Nyat and Naoyapuru, were visited only by the anthropologist, since the other members of the assessment team had visited them previously.

Additionally, observations of everyday situations while walking through the villages, doing the interviews or waiting for the next interview participants to arrive, as well as during introduction meetings with community leaders, fed into the analysis of the research questions. Water points, like pumps and rivers, were additionally visited, as access to water and personal hygiene were also part of the conversations and interviews.

Since the team did not reach out to Pochalla, the Annuak were not part of the anthropological assessment, and neither were the Kachipo who live in Mewun. Therefore, this report focuses on:

- Highland Murle (agriculturalists)
- Lowland Murle (pastoralists)
- Jiye (pastoralists)

\(^6\) Please refer to the anthropologist’s work plan in the annex.
3.3 Selection and recruitment of study participants

The study team conducted forty interviews, 18 in-depth individual interviews; 6 paired interviews; and 16 group interviews. A total of 108 people were interviewed. Convenience sampling (stratified according to people’s backgrounds) was applied for interviews with the general populations in the different communities.

Upon arrival at the different locations, the assessment team arranged a meeting with the local authorities and community leaders to explain our visit, its objectives and intentions. It was asked if the anthropologist and translator could move freely around the villages, and whether we were allowed to approach prospective participants for the interviews. In some locations we had to find a translator for the anthropologist.

3.4 Assessment process and data collection

The data collection process was divided into three phases:

- Phase I was a preparatory phase prior to the field stay, starting in November 2020. This phase focused on discussing and validating the ToR, searching for literature, reading articles and documents, and compiling a question guide for the interviews.
- Phase II started on 16 January 2021. This phase consisted of data collection for seven weeks, from 16 January to 26 February, including qualitative in-depth interviews (18), paired interviews (6), group interviews (16) and observations. The study team consisted of the principal investigator (PI), a female medical anthropologist and various male translators (6) according to availability, ethnic group and language.
- By phase III, end of February, data collection in the field was complete and the first findings presented. Transcripts were finished by mid-April, coding with NVivo and data analysis was done subsequently, and a report was written up.

3.5 Data management and analysis

Hand-written in-depth interviews, group interviews and notes taken during interviews and observations were transcribed from the local languages straight into English (one-step transcription). Data analysis was conducted by the PI using NVivo©11 qualitative data analysis software. All interview transcripts were imported into NVivo after transcription, where they were coded. The analysis involved a thematic content analysis by Mayring (Mayring, 2010). The transcriptions were screened for relevant information, organised, coded, categorised and interpreted. A category (label) was attached to the statements in order to structure the data. The content was analysed in two ways: descriptively, i.e., describing data without reading anything into it; and interpretatively, i.e., focusing on what is meant by the responses (Hancock, 2002).

A methodological triangulation was applied: in-depth individual interviews were combined with group interviews, observations and a literature review (Brikci, 2007).

3.6 Ethical considerations

All participants who agreed to take part in the assessment have been adequately informed about the anthropological assessment purposes and have given their oral consent. Informed consent was obtained in verbal form from all respondents in the assessment. Participants’ confidentiality was respected, and the data obtained through interviews was anonymised without the inclusion of any personal identifiers.
4 Results

This report provides an analysis of the main healthcare needs and current access to healthcare of the population in the GPAA. The results section summarises their main health problems, how people experience and navigate their health-seeking behaviours and explore the scarce and unsatisfactory healthcare choices available to them, what alternative healthcare options exist, what the practices of traditional, complementary and alternative healthcare providers are, when, how and for what ill-health conditions they are consulted, and finally, what factors influence where people seek care.

Since all the information gathered is analysed from the perspective of individuals interviewed, the results are presented according to the different understandings that emerge. The findings are underlined with quotations to give the people who were interviewed during the field visit a voice.

After one week of conducting interviews, it quickly became clear that the main factor influencing health-seeking behaviour is the availability of healthcare facilities per se.

Health-seeking behaviour in such a context, however, is still guided by several interrelated factors, to form a complex net of determinants. These determinants can be put into four categories (Hausmann-Muela et al., 2012). We have slightly modified this model and have added a fifth and sixth category looking at the perceived quality of care provided, to better fit the findings and analysis of those in the assessment area:

1. **Illness perception** and explanatory models (EM)\(^7\) – determines if the disease is treated by a traditional healer *ngari* in Murle and *amuron* in Jiye
2. **Decision-making** and **social values** – decision is taken by the husband and corresponds to the availability of healthcare and the family’s financial resources
3. **Access to care and resource seeking** – either no healthcare facility is available or is it is inaccessible/not affordable, like Boma and Kapoeta or Ethiopia (financial resources, means of transport, rainy season, etc.)
4. **Medical pluralism** – home or self-treatment; traditional, complementary and alternative medicine; biomedicine
5. **Perceived quality** of services available and provided – staff’s attitude to and expectations for medication (quantity and type of medication)
6. **Prior experience** of different healthcare facilities – MERLIN services in Boma compared to CARE services, giving up faith in traditional, complementary and alternative medicine

The results section is structured around the study’s objectives and principal themes that emerged from the interviews. We will first present the healthcare options that are available to and used by the study participants, and then go into traditional healers’ and TBA practices as examples of healthcare options, followed by an analysis of health-seeking behaviours and the factors that influence them.

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\(^7\) Referring to the explanatory models of Kleinman, 1984.
4.1 The lowland and highland Murle

The Murle have two distinct lifestyles and there is cultural diversification – the lowland or pastoralist Murle and the highland or agriculturalist Murle – however, they do consider themselves as one people, as Diana Felix da Costa recognises in one of her publications about the Murle and their identity: “We are one but we are different” (Felix da Costa, 2013). So, the primary difference between the highland Murle and lowland Murle is their means of livelihood. The lowland Murle, who make up the majority and who live in the Eastern part of GPAA, herd cattle and other animals, since cattle breeding is considered an ideal way of life by the Murle. As Lewis puts it, “...cattle are the basis of the philosophy of life. They breed cattle, marry with them, eat their meat, drink their blood and milk, and sleep on their hides. ... The Murle live off their cattle, but they also live with them.” (Lewis, 1972). Everything is organised around the cattle, including most of the social activities, like marriage, for example. For the Murle, being wealthy means owning as many cows and bulls as possible. Not having any cattle means poverty. Within the society, cattle are used as a form of money to make loans, to pay the dowry, to exchange for other goods, and more. A delicate balance between owning and owing cattle characterises social relationships between the Murle. Cattle raids are extremely important, both for the acquisition of new cattle and for proving the virtue of young men.

From January to May, the 20-30-year-old men together with the 10-15-year-old boys and girls and other family members from the lowland Murle migrate with their cattle to the cattle camps to find fertile grounds to feed their cattle. When the cattle herd is big enough, people are better-off in cattle camps than in their villages as they have access to milk and blood. However, the absence of cattle due to cattle raiding (the last

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8 More in-depth information on the Murle can be found in “Know more know better” by Nadja Buser, 2008.
9 The publication’s policy brief addresses some of the differences between the cattle-keeping lowland Murle and the cultivating highland Murle from the Boma Plateau in South Sudan.
one happened in June 2020) forces people to cope with lack of food and malnutrition in themselves and their children.\(^\text{10}\)

“... we are pastoralists before our cattle were raided we eat milk and blood [in the cattle camps] now we go to the bush for wild fruits [as food to survive].” I8, GD young men/Youth, Maruwo

The highland Murle, who live mainly near the Boma Plateau (Fig. 7), which lies to the southeast of Pibor, have either lost their cattle or have abandoned cattle breeding to adapt their livelihoods to Boma’s ecology, and have become agriculturalists.

The plains where the lowland Murle live, on the other hand, are not suitable for agriculture, but ideal for herding. Although uninhabited land exists between the lowland and highland Murle, they visit each other frequently, and intermarriage is common and accepted. They feel they need to depend on their fellow Murle during times of war, drought, and economic crisis. In spite of their geographic spread, the Murle remain unified. They speak a common language and maintain close ties. They are a part of a larger group known as the Surma, who originated in Ethiopia. The Surma gradually moved north, mixing with various peoples along the way.

The Murle settlements are made up of a series of houses arranged into a circle. The houses are linked together by thorn hedges, which keep the cattle inside and protect them from harm. The highland Murle also have gardens near their huts. The houses are usually built by the women. They are beehive-shaped (Fig. 8) and made of thatched bundles of grass, though the housing style in Boma is a bit different.

If not converted by missionary work, the Murle are animists and believe that all people, animals, objects, geographic features and natural phenomena are inhabited by a spirit. The word for ‘sky’ and the word for ‘God’ are one and the same: \textit{Tammu}. \textit{Tammu} created the universe, is all-knowing, the supreme judge and ruler, and greater than all things, rain, for example, is understood as a gift from \textit{Tammu} and is equally named \textit{Tammu}. Between God and human beings are the ancestors, who are responsible for keeping a social and moral balance and who either protect human beings, or, if they are neglected, may make them sick (Buser, 2008). Red chiefs (Fig. 9+10) are spiritual men said to have gained their power directly from \textit{Tammu}, and as such, have spiritual authority to rule. That said, red chiefs are not healers; they do not interfere with medical issues. They are mainly responsible for keeping a balanced atmosphere in their villages in terms of conflict resolution and moral support. The red chief’s role is inherited from father to son.

\(^{10}\) Please also compare this to further explanations of the consequences of lack of cattle in chapter 4.2 on the Jiye.
“We fulfil two roles, we are controlling cases in the community, our aim is that everyone is in peace. We are advising people to go for cultivation for survival. When the young ones go for fishing and hunting [we tell them] don’t go for fighting; the government told us that we should control the society. If you don’t do what they [the red chiefs] say, something bad may happen to you, cursing can happen, you can be bitten by a snake, you might be killed.” I16, GI leaders, Labarab

“The red chief has to call upon Tammu [God]. Tammu is telling the red chief how to solve the problem. If someone is not respecting the red chief, something will happen to that person. That is why people are respecting the red chief.” I21, leader, Boma

The Murle who are not converted to Christianity solicit the help of traditional healers and diviners when they intend to ward off evil spirits and curses. We will go more in-depth into traditional healing practices in the chapter on alternative healthcare provision.

Common to other pastoral societies in East Africa, in Murle society, age-set systems, a sub-structure of the generation-sets, are well-defined groups of men based on age, which accompany them through life, although these age-sets are most important in youth when young men are searching for wives, and have a responsibility to protect the community (Felix da Costa, 2013).

Within each age-set, there is a certain internal hierarchy through a number of internal subcategories, where ultimately, the ‘elders’ of each particular generation often have a more prominent role. This is why some young men choose to drop an age-set, for example from the older Bothonya to the younger Lango, where they become one of the seniors within the Lango. The age-sets usually last for roughly a ten-year span. The periods between age-sets have shortened significantly through the widespread availability of firearms, as new age-sets emerge and compete with older ones that have not yet had the chance to establish their power and dominance (Felix da Costa, 2013).

One main difference between the highland and lowland Murle is reflected in the age-set system. There are two main principles around which Murle society is structured: age-set systems and clans. Age-set systems structure a culture horizontally (everybody of the same age), while clans do it vertically (everybody who belongs to the same family).11 This is practised among the lowland Murle, however, the highland Murle join the age-set according to interest and not according to age. Interest here means that a young man will choose an age-set which displays behaviour he or his family likes. While in Pibor, the Lango are the dominant age group at the moment, in Boma it is still the Bothonya. In Labarab, for example, where I met the younger group of Kurenen (15-21 years), the youngest age-set, they explained that they are afraid of the generation

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11 The oldest age-set group are the Dorongwaa and the youngest are the Kurenen (please refer to annex 7.3)
fights of the older Kurenen (20-30 years) who want to take power from the Lango in Pibor. In Boma, on the other hand, there is no Kurenen generation so far among the highland Murle. Furthermore, the members of the Kurenen age-set are considered troublemakers.

4.2 The Jiye

The word “Jiye” means combatant (Bader, 2012). The Jiye are an agro-pastoral community; the core of the Jiye habitat is situated in the vicinity of the Kassangor Hills, on the border between Kapoeta and Boma. Two places, Kassangor and Naoyapuru, which were part of the assessment, are inhabited by the Jiye population; they count less than eight thousand, which makes them one of the smallest groups in this part of South Sudan. It is a particularly resilient society, which, over the two centuries of its existence, has survived periods of extreme drought and famine, severe cattle diseases and periods of devastating raids by their more powerful neighbours, the Toposa12 (Verswijver, 2015).

Fig. 11: Jiye woman       Fig. 12: Jiye man lying under a tree with his age-set group

The climate in their living areas is arid with heavy rain downpour between April and October. The Jiye herd cattle, sheep and goats in a traditional manner and engage in subsistence cultivation of Sorghum and tobacco. They practice transhumance in search of water and pastures for their herds. It is safe to assume that there are crop failures every three years, and that approximately every ten years, the area faces a drought disaster that affects even the animals, who otherwise survive due to their high level of mobility. In recent years, rainfall patterns have become even more irregular, i.e., distribution within a year and across several years has become increasingly unpredictable, which hampers agriculture even more. Under these adverse circumstances, people can only survive by relying on a complex system of mutual support, networking, and social ties. These ties are established through the exchange of animals, and they are not only symbolic but also very practical in times of need. For example, after a drought, when a man’s animals have died, he might ask a more fortunate relative or friend to return some animals to him in order to build up his herd again. One context where this network of mutual ties is manifested in a special way is marriage. Here, a man marries

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12 The Jiye and the Toposa people share the same lifestyle and culture, and have lived peacefully together for many years. In recent years, violent cattle raiding between the two ethnic groups has led to loss of livelihoods, i.e., cattle.
more than just a wife; he marries her family and relatives as well. The woman, in turn, becomes part of the man’s family – and also part of his age- and generation-set (Mueller-Dempf, 2017).

However, drought catastrophes can also have a negative impact on the generation-set system in an indirect way. During a catastrophic drought, most of the people’s animals are likely to die. Thus, when there are no animals available, no bride animal wealth can be raised by young men, which, however, is considered essential for an orderly marriage. The non-existence of bride animal wealth encourages relationships outside of wedlock, since young people may not stop having sexual relations and creating children. This is likely to continue until the herds are rebuilt and bride wealth can be established again, resulting in ‘real’ marriages. In the meantime, the children born out of wedlock are deemed to be the offspring of the girls’ fathers (Mueller-Dempf, 2009). This could be the case for the Jiye in Kassangor,13 as they have lost all their cattle, not only to natural catastrophes like droughts but to cattle raiding as well.

"How will the lack of cattle influence the marriage?
We have been married, everyone has NO cattle now, so we can marry without cattle and later if you have [cattle], you can give your cows [for the dowry].

How do you see the future of Kassangor without cattle?
Seen the livestock has gone finished, all people, even small children and old men have been affected because there is no sources of income. Even the sorghum you have no sauces to eat with it.” I40, GI leaders, Kassangor

There is another feature that is relevant to an understanding of some of the dynamics of the system: The antagonism between fathers and sons. Jiye are polygamous, i.e., men may marry as many women as they want, provided they can give enough animals as dowry for another marriage. Therefore, the situation may arise that an old man still wants to marry another wife, while he has sons of marriageable age who want to start a family of their own. Because of the old man’s plan, the sons are deprived of their reasonable wish to marry (Mueller-Dempf, 2017).

The society is organised into exogamous patrilocal lineages.14 The most important social events that bring the Jiye together in celebrations include marriage, hunting, cattle raids and warfare. The Jiye share certain totems and body marks. Male adults attend meetings, gatherings and functions in which important decisions concerning the clan or whole community are made. Among the Jiye, respect for the elders is mandatory for the younger generations. The Jiye have no clear political organisation or functions. The chiefs, subchiefs, elders, fortune-tellers, medicine men and witch doctors wield administrative and spiritual powers.

13 I have put exactly this question to the leaders in Kassangor. Given more time, it would have been interesting to dig a bit more into the dynamics of marriage and the lack of cattle due to natural and man-made disasters, and to see to whom the children born from these unions belong.
14 This means that the Jiye have to marry outside their clans, and that the married couple settles in the husband’s family.
A woman’s tasks are digging the garden, building houses, fetching water and cooking food. Men’s tasks are accompanying the cattle and digging the garden, hunting and fishing. At the time of the assessment, most men were on the Barbar river to fish and were due to come back with dried fish later. The Jiye build their houses very close to each other (Fig. 13) because they fear their enemies, and with huts structured in this way, the families are better able to protect each other. The houses are built in a two-storey style (Fig. 14) with a room at ground level and a granary on the upper level. The entrance is made in a low and narrow style to protect the houses from burglary.

Like the Murle, the male Jiye population is organised around a variety of generation and age-sets. The Jiye systems are not only systems of age; they are, first and foremost, generation systems. They do include age-sets, but these are inseparable from the generation system and form a sub-category, a workable sub-division for day-to-day affairs. An age-set system, therefore, incorporates males of approximately the same biological age for the purpose of advancing them up a series of distinct societal levels, each of which requires them to perform certain duties and to follow certain behavioural norms. Ideally, no two age-sets occupy the same age-grade, as each senior age-set vacates its age-grade prior to its occupation by a junior (Mueller-Dempf, 2017).

Among the Jiye, girls form age-sets of their own. After marriage, a woman is incorporated into the generation- and age-set of her husband. On this occasion, her former female age-set celebrates with her and receives an ox slaughtered by the future husband. The married woman then becomes attached to the generation-set of her husband, and her own age-set is said to lose importance. It seems that women’s age-sets are not as intricate and do not have the same political relevance as those of men (Mueller-Dempf, 2017).

The Jiye believe in a supreme being named Apayok, who resides in a crater in Mount Kassangor, as well as in ancestral spirits, who may assist them in overcoming problems, such as drought, or epidemics of disease among their herds. They pray and make sacrifices for these spirits as they communicate with them through a medium; this can be the fortune-tellers or traditional healers; both are part of what is called the amuron. Most traditional healers are women. The term ‘witch doctor’ was mainly introduced by missionaries who tried to convince the population of the ‘evil’ doing of these healers, since they were also dealing with supernaturally caused ill-health conditions.

**Intercommunal violence among the Jiye in Kassangor**

On several occasions during visits to different places in Kassangor, a high level of intracommunal and domestic violence was observed, and it was also frequently reported in the interviews. Women who walked
by while interviews were being conducted showed the wounds on their bodies; one woman who had been beaten by her husband was also drunk when she walked by; the same was true for another woman, who showed her infected ear from a dispute with another woman. We suspect that this intracommunal violence is mainly due to the high consumption of alcohol, with other secondary reasons also contributing. In an interview with young men, it was explained that women ‘fear’ their husbands and that they have too much ‘respect’, resulting in not always telling him when they do not feel well or are sick. It was said that the husband would think that she ‘pretends’, and, if she is not fulfilling the tasks that are expected of her, she will be beaten by him. This was mentioned on various occasions by men, women and youths. Further, it was emphasised that if a woman did not ‘obey’ her husband she would be beaten. In another interview, the team observed another violent situation within the community: among elders, where a woman was said to lack respect for the age-set friends of her husband. Yet another situation of violence was observed at the water pump, where women fought who would be next to fill their jerrycan with water.

4.3 Men – women relationship

4.3.1 Marriage

As exemplified in the chapters on the Jiye and Murle, people can marry only if cows are available to exchange as dowry. The Murle pay up to 50-60 cows and the Jiye said they had to provide up to 200 cows. The highland Murle do not exchange cows but pay an equivalent amount of money for the dowry.

“I booked my wife in 2013, she was 17 by then. I chose her and I informed my parents, they accepted and approached the girl’s parents and agreed. We married in 2016, I did not pay cows, I paid money in the equivalent of 20 cows (20,000 SSP/cow)\(^{15}\). I saved the money at home while I was working. After marriage the wife comes to my home [at the husband parent’s place], you [the husband] build your own house to life together with her.” I26, young man, Boma

Marriage can be a long process until a young man is able to build up his cattle herd to have enough cows to marry. A young man at the age of around 20 years will not be married yet but he may have ‘booked’ a girl he wants to marry later. The ‘booking’ is done either by the young man in agreement with the girl or by his parents.

“K. is booking his girl now; the booking was done by his parents, now he is engaging with her, he can go there to talk with her, chatting with her, etc. but during dances the girl should not dance with him but with his friends. It is shameful, she fears to play with him in front of the group.” I17, GI youth, Labarab

However, a ‘booked’ girl can still decide to marry another one and therefore the young men often do have rivalries regarding girls and young women.

“The challenge of generation fighting is within the same age group, sometimes they fight because of the girls. Within the Kurenen there is different engagement with girls, they do not mix, so e.g. 20-30 [year old Kurenen] they have their own group, then the 15-20 [year old Kurenen] they have their own group. Sometimes they want to convince the girls to come to their own group and at the same time we expect the war from the Lango generation.” I17, GI youth, Labarab

Women are highly valued in both the Jiye and Murle populations because they bring wealth to the families upon marriage. Girls bring cattle to the families, which then also allows her brothers to marry. This was often explained in the interviews; when a sister marries it makes it possible for her brother to marry subsequently. So, cows can be seen as permanently ‘moving’ capital in respect of marriage.

\(^{15}\) 1$ = 500-600SSP in February 2021
4.3.2 Sexuality and pregnancy before marriage

The Murle and Jiye are quite liberal in their sexual behaviour before marriage. However, it was observed that with the increased influence of Christianity, moral values became more important, and people said a young woman should not have sexual intercourse before marriage. This was the case in Maruwo.

“We have a taboo, all our girls should not play [having sexual intercourse] with the boys, a girl should wait, girls should respect themselves [abstain] until when they are married. The girls sleep with their brothers [in the cattle camp] and they will watch over them. Our girls are meant for cows. So you have to wait until you are married.” I3, GI leaders, Maruwo

This is in contrast both to other areas assessed and to findings from an MSF anthropological report from Pibor about the Murle (De Marez, 2009b). Pregnancy with a lover should be avoided and the men said the girl was responsible, since only she knows her menstruation cycle. If a girl does get pregnant before marriage, the family will either try to marry her to the boy or man who impregnated her. If this is not possible, he has to pay a fine which can amount to 15 cows to the girl’s family. The highland Murle follow a special rule when a boy who has impregnated a girl will not marry her. When she gives birth, one parent has to attend the delivery:

“In case the girl is not married to the boy, and she gives birth at her home a female parent of the boy has to come to attend the delivery and has to bring a goat and the goat has to be slaughtered and given to the mother who gave birth. They term it to be a sacrifice and a blessing for the child to raise in a good way. This is when they will not marry.” I34, young man, Boma

The fact that an unmarried girl already has a child does not impact negatively on her future marriage prospects; on the contrary, it proves her fertility. Her future husband will still pay the usual number of cows and the child is considered his child. This is what Mueller-Dempf calls the ‘social fatherhood’; it is not so much the physical father who counts but the social father (Mueller-Dempf, 2009). We will come back to this feature in the chapter on infertility and impotence.

What is not allowed is engaging with married women, and there are serious consequences for the Jiye, as this young man explained in our conversation:

“With the Jiye they say if you have sex with another person’s wife you can die, either woman, man or child. It is taboo with a married person [to have sexual intercourse], you can have a unmarried girlfriend, but not a married one.” I33, young man, Boma

4.4 General ill-health conditions and main healthcare needs

4.4.1 Disease causation

Where the disease comes from, what leads to sickness and why somebody becomes ill."

In this section, we will discuss the main ill-health conditions that were mentioned in the interviews. People talked about health problems in the same breath as ‘water problems’, as without access to clean water good health is not possible.

In general, it was said that every disease is ascribed to God, but people can avoid getting sick by complying with behavioural, social, and moral rules. To get a better understanding of traditional attitudes and

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16 In Medical Anthropology, we differentiate between disease, the constellation of symptoms, illness the individual experience of disease, and sickness, the social construction of disease (Kleinman, 1984).
approaches to sickness and healing it is important to understand how people see the causation of an ill-health condition, as this determines where they seek treatment for their ailment. What has caused the disease and where is the disease coming from? There are three main categories. Causes might be found in the natural world, like an accident or malnutrition, where the person dies as a consequence. They can also be found in the supernatural realm, where the cause is related to God or other supernatural forces, like ancestral spirits (of deceased persons) or other spirits living in the environment, like the river goddess Nyandit. If someone has failed to show respect to their ancestors, or ancestors are angry about the behaviour of living dependants, they can make a person sick. The ancestors require special attention; they are important, both throughout life and when talking about death.

As heard and explained in the interviews, this is most significant when people refer to traditional healers for treatment, like the ngari for Murle and amuron for Jiye, mainly in Labarab, Kassangor and Naoyapuru. It is also important to look at how much a community has been exposed to Christian missionaries. For example, in Maruwo traditional healers are consulted only by older people and not actually frequently anymore, and the same was said for Boma and Nyat.

According to traditional health concepts, social consequences are always taken into account, especially when the origin of a disease is not clear. If a disease is caused by witchcraft or magic, people will not say who is thought to be responsible and therefore guilty. By contrast, a traditional healer or ‘witchdoctor’ is allowed to identify witches in order to sanction them and to rebuild the disrupted social balance in the community. Among the Murle and Jiye, the main causes of non-natural ill-health were seen in the energy created by curses, spells, black magic or the presence of bad spirits, which can block or even paralyze body and soul, while cursing was mentioned in most cases.

"With which disease do you go to the amuron?
Mental problems, when a person is just running [around]; paralysis of the body, so not able to walk or stand up, or not eating, the body is in a coma.” I30, GI men, Naoyapuru

In any case, if the disease is suspected to be caused by non-natural agency, people will first consult a traditional healer, who either uses divination to verify if witchcraft is involved or not. They also consult a traditional healer when they strongly believe in witchcraft.

"Why do you go to the amuron?
We go there for check-up [through a divination], to know if there is witchcraft or not. ... We combine them [healer and hospital visit] because we want the amuron to know this sickness, if it is for amuron or for the hospital. We cannot know if the disease is for the hospital or for the amuron.” I39, male leader, Kassangor

Among the main ill-health conditions like fever/hot body/malaria, diarrhoea, breathing problems and chest pain, rash, etc., which we will stratify according to gender and age in the following subchapters, leaders in the different communities also mentioned outbreaks like cholera and measles.

A very interesting feature was seen in Maruwo, where people talked about ‘new diseases’ in the interviews. It was quite difficult for me to understand what they were referring to as they said these ill-health conditions were new, and that they had not encountered such conditions before. In a discussion with an ACF nurse in Maruwo we were quickly able to identify what people were referring to:

"There is another one [disease], it starts in the head with staggering and dizziness, it attacks the brain and head, it feels like a drunken person and it attacks all women and men and children.

17 We have to consider, however, that this classification follows a Western way of categorising.
It is a new disease, it started in 2017. ... Another disease for pregnant women when they are in the period of 6-8 months their body swells and as we do not have good services women died. This is also a new disease!” I3, GI leaders, Maruwo

“There is some disease that happens to the child, it is convulsing, we don’t know that it is suffering. This is a new disease.” I9, GI TBAs, Maruwo

One of these conditions was identified as hyperglycaemia in an interview with the ACF nurse in Maruwo, who indicated that it was not a new disease but that it is appearing more frequently now because of hunger. For convulsions in children, the TBAs assumed it could be Malaria and said “you call it malaria in English but we call it yellow fever tadiyon-ci-maan, which means ‘malaria in yellow colour’”.

4.4.2 Pain perception

In Murle and Jiye society, it is frowned upon to show pain. This is especially the case for men, who are reluctant to present or explain their suffering to their wives. A man has to be strong and should not show any weakness. This is an important feature when it comes to health-seeking behaviour. In a group interview in Maruwo, a woman said: “A husband feels superior, he will never tell his wife that he has pain.” (I4, GI women, Maruwo). This finding was confirmed in another interview, where it was said that people were very strong in tolerating pain. In her guide document to the Murle in South Sudan, Buser writes, “they are able to bear pain silently, a competence they learn through war, painful rituals and giving birth for the women” (Buser, 2008). During visits and interviews in the villages and at mobile clinics, some observations confirmed this impression. When children were rebuked or disciplined by their elders, they did not try to escape the blows but stood completely still and endured the pain, since it was deemed unheard-of to dodge them.

4.4.3 Prevention of disease

Not much information was gathered on what steps were taken to prevent disease. For a new-born baby, the TBA would pronounce some spiritual blessings to protect it from ill-health and other bad forces. A traditional healer in Maruwo explained some protective measures she uses against infertility in men and women, and to protect someone from curses and spells.

“I use a stick from a tree, leaves and make ashes, I burn it and we wear it around the neck or as a bracelet around the hand for a man [against infertility]. For the man again on the leg, as a protection against the curse form the ancestors or anyone.” I12, traditional healer, Maruwo

During MERLIN’s time in Boma, people in the vicinity received information on why and how to use mosquito nets in order to promote their health. In Labarab, people also learnt how and why they should use a mosquito net and understood that it was to prevent mosquito bites and malaria. But in an interview with community leaders, a man complained:

“It [the mosquito net] should stop you from getting malaria. If you have already malaria in your body this mosquito net cannot treat you from malaria, we need treatment for malaria.” I16, GI leaders, Labarab

In the various locations, mosquito nets were seen inside and outside the houses, used for sleeping under, like for this mother with her new-born baby (Fig. 15) and also for constructing houses, while it was said that only broken and useless mosquito nets were used in construction (Fig. 16).\textsuperscript{18}

\textsuperscript{18} In a personal communication I was told that some also use brand-new nets for construction.
Other uses for mosquito nets were also observed, like protecting entrances (Fig. 17), and mosquito dumurias\(^{19}\) (Fig. 18) for more discretion within bigger families, or as a substitute for a ‘normal’ mosquito net.\(^{20}\)

### 4.5 Ill-health conditions in men

As said earlier, men did not permit themselves to show pain or weakness. However, during the interviews it became clear that the men suffer from ill-health conditions just like the women do, and they were not hesitant to talk about them. The main concern that men did continuously mention were ailments related to STIs. Apart from STIs, the main health problems mentioned for men were TB, chest pain, coughing, haemorrhoids, malaria, and joint pains in elders; with the younger men, it was injuries from generation fighting, and gunshot wounds from cattle raiding. In one interview, a group of young men replied:

“For men, we are the same like children, we suffer from malaria, diarrhoea, especially chest pain and TB and we face this bongka [gonorrhoea] and dolach [syphilis].” I24, GI Boma

In an interview with a group of women in Boma, the same ill-health conditions were confirmed, highlighting especially the treatment of injuries and haemorrhoids:

“Haemorrhoids are common for men, they used to sit for a long time in chairs. Two to three years ago there was communal fighting between the Murle against the Jiye and Toposa; the wounded people found it difficult to get treatment but the aritnya [traditional healers] are good in joining the bones.” I1 GI women, Boma

\(^{19}\) Non-mesh mosquito net (Gore-Langton et al., 2015).

\(^{20}\) This characteristic has to be assessed; the photograph is from Maruwo.
In Naoyapuru, men complained of swollen testicles, worms in the stomach, stomach pain, and again of STIs, explaining that urinating became difficult and painful with discharge coming with the urine and the urine described as burning.

4.5.1 STIs, syphilis, gonorrhoea

Men and women alike did talk about one main ill-health condition which was referred to as dolach in Murle and lokot in Jiye, and was translated as syphilis. In every interview, this condition was mentioned among the main health problems with severe consequences when it becomes chronic. It was not always clear if people were talking about syphilis or gonorrhoea, or another STI, as all the conditions were subsumed under the term “syphilis”.

When talking about main health problems, people started to talk about lower abdominal pain and back pain. These were the symptoms mentioned in relation to syphilis. It was explained that it is “inside the body and that it is paining inside.”

Reasons for getting syphilis were in most cases related to the lifestyle of having as many women as possible in marriage, and also outside of wedlock. In discussions with men, it was acknowledged that apart from their wives, men do have unmarried girlfriends, which adds to the spreading of STIs. It is this hegemonic male behaviour which expects and assumes that a man needs girlfriends even when he is married:

“We don’t know who brings the disease [syphilis], we cannot say the women bring it, the men cannot stay like this [without sexual intercourse] even if he is married, you have to look for the girls and then they can bring it [STI] to their wives, if you have no treatment it rotates and continues.” I11, health staff, Maruwo

“The reason syphilis is spreading everywhere is the lack of treatment, if one person has it and he or she is not treated this disease is going to other people. It is true if you have girlfriends somewhere and you have this sickness you give it to them, it is due to the movement of people.” I24, young men, Boma

“It is the lifestyle, if you marry you don’t know whom you marry, you do not test. The polygamous lifestyle, and the men have girlfriends and the women have boyfriends.” I32, health staff Boma

In a group discussion with young men in Maruwo, they raised the concern of transmission via transactional sex with soldiers that are stationed there. The same reason was given in a group discussion with women.

“... we have so many soldiers here so the abdominal pain and back pain like dolach it comes from soldiers, because they move a lot. Maybe they slept with our women.

How can your women sleep with them?
We do not control them, she is a human being and another problem is the hunger, the soldiers have money so they can easily get our women. When we migrate from here [to the cattle amp] the women stay back. The soldiers live around here they are many.” I8, GI young men, Maruwo

In one interview with a group of men from Nyat, they talked about syphilis, gonorrhoea and HIV and how they would treat it.

“For bongka [gonorrhoea] there is a certain leaf, very green, in a swampy area, we cut it, chop it and apply it on the private parts, or we add water and drink it. We take these herbs, but it cannot treat this gonorrhoea, we get it from a woman or vice versa a woman gets it from a man. So to stop this, it is

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21 In the short time I had it was not possible to get the exact significance of the word dolach, as people always said it was syphilis. Among the Jiye, lokot was mentioned in relation to syphilis but was explained to mean ‘blood’ in a literal translation.

22 I am a bit reluctant to use the word syphilis, as it was not always clear whether people really meant syphilis when using the word dolach.
difficult. This one needs a hospital to get treated. L. suffered from from bongka, he went to Ethiopia and was treated there and was cured in a few days. Now the reason we don’t go to Itty [Boma PHCC], there is not good treatment and hospital to help us.” I27, GI young men, Nyat

In the same interview in Nyat, the interviewees emphasized the difference between gonorrhoea and syphilis:

“There is a difference between dolach [syphilis] and bongka [gonorrhoea]. Gonorrhoea can appear within some days you feel pain in your penis and it is itching and you see a lot of discharge and it can be treated in a few days. For dolach [syphilis] it cannot appear, it moves in your body you feel back pain and lower abdominal pain and the few discharge you can see, it cannot appear in a few days, when it appears in your body it has stayed there since long time and the treatment can also take long and cannot cure in a few days.” I27, GI young men, Nyat

The first and only time that people talked about HIV was in Nyat. The condition was mentioned in relation to TB, and that people would go to Ethiopia for treatment where they were tested for HIV and found positive. The young men explained that the moment to go to Ethiopia usually came after these persons had been suffering for a long time and had lost weight:

“Someone begins with a simple sickness and it stays and the person becomes so thin, so they went to Ethiopia and they find him positive [HIV] tested.” I27, GI young men, Nyat

Lack of treatment or lack of access to treatment was another reason mentioned why syphilis and STIs are so widespread. Concerns were raised for people living in cattle camps, because treatment takes four weeks, involving a weekly injection and pain. Patients sometimes do not finish the treatment because they want to go back to the cattle camps.

However, in general the problem does not lie with the patients who do not start or finish treatment but rather, with healthcare provision not being able to offer the treatment at all; a real concern raised by healthcare staff in Boma.

People explained that, due to a lack of access to medical care and treatment, they try to deal with dolach and other STIs using traditional medicine, like herbal or animal-based treatments. For dolach, people use animal fat from a cow, goat or sheep. They slaughter the animal, cook it and extract the fat, which the affected person is given to drink. But people always emphasised that this is what they did when there was no access to other medical treatment.

“... this one [syphilis] some time ago people treated it with the oil from the cow, sheep or goat, we eat fat and take the oil to drink but now people prefer the health facility for treatment; people in the cattle camp are still using the oil.” I28, GI women, Nyat

4.5.2 Impotence\textsuperscript{23} caused by ‘dolach’ (syphilis)

Syphilis was especially mentioned in the context of impotence in men and infertility in women. Men explained that when they suffered from prolonged STIs, they were no longer able to engage in sexual intercourse with their wives, and that they feared being laughed at by their women. In a group interview with men, one respondent\textsuperscript{24} admitted that he was suffering from ‘dolach’ (syphilis):

“Do you see all three wives?
I used to go to all three of them, now my power is not there anymore because of dolach. Now am not going to see anyone.

\textsuperscript{23} For men, infertility translated to impotence, whereas for women, it was said that they were barren.

\textsuperscript{24} He is around 50 and has three wives, the youngest being 18. He married her just a year ago and she has not given birth yet because he is suffering from an STI.
What do you do then?
You can die, if it [the STI] is stopping you from producing [having children] maybe I will not die but it will be difficult for me having three women and not being able to reproduce. I can only commit suicide, killing or hanging myself. Suicide is very common in men, it is common, people will not say that he committed suicide but that he died. It is a big shame for a man; if you cannot produce you become useless. Your wife can lose respect of you and they look for other men outside and bring a man to the home. Into the same room where the husband also sleeps, so he can kill this other man and then also kill himself. If the woman does not respect her husband anymore, she can bring the man home. It means she doesn’t care. The husband has to react then for his honour.” I16, leaders, Labarab

The problem of STIs and the frequency of references made to syphilis show the magnitude of the problem. We will further discuss the topic of ‘dolach’ in the chapter on sexual and reproductive health and infertility in women. In that chapter, we also discuss the matter of ‘producing children’, its importance to a couple’s relationship and the creative solutions found when either the man or woman is infertile.

4.6 Ill-health conditions in children

The main ill-health conditions mentioned for children were malaria and diarrhoea, skin infections, RTIs, eye problems etc. But people also spoke about other common childhood diseases, like typhoid, polio, mumps and measles, which children were vaccinated against in areas with access to healthcare. All these diseases were said to start with the rainy season and to be prevalent from July to January mainly, although malaria was present throughout year. Diarrhoea was more frequent in the dry season, while itching was specific to the rainy season. This section is not at all exhaustive, and we describe only a few conditions, but, as in other areas, there might be some traditional disease concepts that would be interesting to consider in greater depth. Here, we present only those conditions that were referred to most by the interviewees.25

4.6.1 Malaria – ‘hot body’/fever/convulsions

People mentioned that malaria was the main problem in the area and that children got a ‘hot body’, in Jiye, amana akwan, or fever, in Jiye, arkom. In Murle language, tadiyon refers to fever or convulsions. These are all ways to talk about malaria and can be subsumed under this term. The Jiye terms akwan and arkom are equivalent to malaria. When people talk about tadiyon, they explained that it means fever combined with convulsions, which can be understood as severe malaria, as observed earlier in a quote where a woman explained that they call convulsions ‘malaria in yellow colour’. One Jiye woman differentiated between fever and malaria:

“Fever is when your body is hot, malaria is when you are really sick, the child is vomiting and refuses to eat, losing weight, not eating, sleeping down.

How do you treat the aman akwan?
There is traditional medicine, a small tree called amaret, we take the root, put it into the water and give it to the child to drink, we boil it for 1hr. It will help sometimes for the fever, for Malaria it will NOT help.” I36, woman, Kassangor

In most cases, people explained that the child is treated with local herbs.

“I have children, they have malaria and other diseases like typhoid and diarrhoea, I use local herbs to manage these sicknesses, sometimes it can cure, sometimes not, if I try to take them to the hospital

25 The information in the reports of the medical person of the assessment completes the picture.
[Boma PHCC] I cannot get good treatment there. We can only continue the way like it is, there is nothing we can do.” I24, GI Youth, Boma

“For all these diseases [malaria, diarrhoea, itching, etc.] we do not have medical attention, we use leaves and barks and use traditional medicine. Sometimes you go to the arit [traditional healer] with a critical condition but when it is in the first stage you treat it yourself.” I3, leaders, Maruwo

Even in locations closer to the PHCC in Boma, people draw on traditional treatments, as the quote above exemplifies. In Kassangor people said they would take the child to the ‘witch doctor’ who asks them to bring a goat. The traditional healer will slaughter the goat and sprinkle the blood on the child. Additionally, the healer will always massage the child’s body in a ritualized performance to ‘take out’ the witchcraft. In such a ritual it might happen that the healer shows the audience an object she or he has ‘taken out’ of the sick person’s body as proof of the disease and competency of the healer. On other occasions, the healer makes incisions in the patient’s body to ‘extract’ the ‘bad blood’ from it. Sometimes, before reaching out to the traditional healer, people try to treat the child with herbal treatments at household level, or by putting some wet cloth on the child’s body to cool it down.

“For any sickness the traditional doctor will massage the body of the child and they will take out the witchcraft. After that the child will be ok.” I35, woman, Kassangor

It was not entirely clear if people made the link between the mosquito and malaria and how to prevent it; mosquito nets were distributed and people used them to protect themselves because “when mosquitos bite you all night you wake up very lazy and you are not feeling ok” (I16, leaders, Labarab). However, the mosquito net was understood to protect people from getting bitten. People observed that the mosquito net cannot help if the malaria is already in the body, and so the mosquito net was understood not to be a treatment. This means that people referred to treatment instead of referring to protection.

4.6.2 Diarrhoea, watery and running stool, bloody stool and ‘chuguk’

Diarrhoea is another serious ill-health condition mentioned in the interviews. Watery and bloody diarrhoea are caused by dirty drinking water. In some interviews, it was said that it appears more in the dry season, but in others, people acknowledged that it does happen all year round. People explained how diseases appeared according to the seasons:

“During cold weather in autumn in August, September and October when there is too much rain, we suffer from chest pain, joint pain and also diarrhoea and stomach problems; headache and shivering come with the dry season from December to March.” I2, TBA, Boma

*Chuguk* is an ailment mentioned in relation to diarrhoea and was described as the child having cracks around the anus with continuous diarrhoea. As for other childhood diseases and ill-health conditions, people turn back to traditional healing with plants, which they collect themselves.

“There is a disease called ‘chuguk’, it attacks the anus of the child with some cracking around the anus and the mouth, so the child keeps on having diarrhoea. We boil the tea leaves and insert this into the anus of the child, like an enema. If that does not work you use the neem leaves, cook it well squeeze and insert the juice into the anus.” I1, GI women, Boma

“The same way as the women in Boma, we search in the bush the bitter leaves, boil in water take the liquid put it in a syringe and put it into the anus of the child. Sometimes it helps but many die.” I3, GI leaders Maruwo
In Boma, women spoke about what they remembered from health promotion sessions conducted by MERLIN and explained that they were still using the sugar and salt mixture they were told to at the time. But they also fell back on traditional treatments when other effective drugs were not available.

One perceived cause of diarrhoea in children was the mother being pregnant again and continuing to breastfeed her child.

### 4.6.3 Measles, mumps, typhoid and polio

People frequently mentioned childhood diseases which children would normally be vaccinated against, and which therefore should not appear anymore. Immunization is an issue, since most people live far away from formal health facilities and going there after childbirth is too complicated in terms of navigating available resources. In an interview with an ACF nurse in Maruwo it was mentioned that they encouraged women to go to Boma for immunization. In another interview, I was told that women did not go because it was too far away and there was no guarantee the vaccine would be available upon arrival.

“We have even polio, so vaccination is coming only once a year, diarrhoea, cholera in rainy season, people die like animals.” 136, woman, Kassangor

For treatment, as previously observed, people drew on herbal treatments, like for mumps, or other self-treatment, in the case of measles:

“A disease that attacks the gland and the tongue of children and men and discharge of the ear, it is mumps, there is no medicine, we go for barks and roots and leaves. It only helps a few people but many die. ... There is a disease for small children with rash all-over the body associated with sneezing, running nose and fever, it is measles, tang in Murle. We don’t even try to treat it traditionally [with a healer], we treat it by slaughtering a goat; we use the blood of the goat to smear all-over the body and the soup of the meat to eat, only the liquid. We try, sometimes, with the help of God it helps.” 18, GI, Young men, Maruwo

People talked about outbreaks of yellow fever, measles and cholera and other diseases, and raised the concern that CARE did not react. Only when ACF informed Juba did a team come to vaccinate the children. In an interview with two self-appointed CHWs, they informed us of a measles outbreak in 2020, with 125 deaths in children.

### 4.7 Nutrition and malnutrition

Nutrition is a problem and a concern which the people mentioned in every interview, be it Murle or Jiye, in Maruwo, Labarab and Kassangor. Malnutrition is something that comes with droughts and other natural disasters, with human-made catastrophes worsening the situation. Climate change is one of these: it causes prolonged rains that wash away all crops, and at other times, a lack of rain when it is needed. The soil in some areas is said not to be cultivable because of the black cotton soil, which is extremely dry and cannot absorb the heavy rains, and yet it is fertile. Where there is a lack of food, men resort to hunting and fishing, while women and children collect wild fruits.

“We are going [for hunting and fishing], last year the vegetables have been brought by ACROSS to plant like okra, pumpkin we planted it, but it was drowned by water during the rainy season.” 140, leaders, Kassangor

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26 This dates back to 2013, the year MERLIN left.
Needless to say, when talking about the GPAA, it also depends on the specific area. In Boma and upper Boma, the situation seems to be much better, whereas in Kassangor, Labarab and Maruwo people constantly stressed the significance of food insecurity. It was further emphasised that people had to rely on support from WFP, JAM and ACROSS but that food distribution was not sufficient to overcome the period of hunger. In Kassangor, employees from JAM explained that the MAM rate was high, with 264 cases registered, and that SAM was registered for 55 children in February 2021. This situation is amplified by the fact that a serious cattle raid had taken place in June 2020, resulting in diminished access to cows, milk, blood and sometimes, meat. And cows were reduced not only because of cattle raiding but also due to diseases that further decreased the herds.

“We were good because we had enough cows, enough milk so the children were good. They drink in the morning and in the evening; drinking milk is like having a full meal.” I5, GI women, Maruwo

“For cows to have milk they need to be healthy, last year all our cows were raided, the few [that are left] are attacked by diseases and are dying. ICRC came and did some vaccination and it seemed they were adding diseases because more cows are dying now. The Nuer and Dinka raided them all, also the Toposa, last year in 2020.” I3, GI leader, Maruwo

In Naoyapuru, a group of men explained how they dealt with the food situation:

“During rainy season we cultivate, sorghum, maize and cassava but we eat only one meal in the evening; in the dry season we cultivate only small and we economise otherwise it finishes quickly. In the dry season we go for hunting and fishing we get little food from WFP, it even does not take a month sometimes only a week to finish.

What about milk and blood?
We do not have cows.” I30, young men Naoyapuru

And in Labarab, a family explained how they dealt with their food situation:

“When we have enough food, we eat porridge in the morning, we eat lunch and we prepare for dinner. When we don’t have enough food, we eat only porridge in the morning and dinner. For lunch we can eat bush meat and Ugali (maize), in the evening greens, like cassava leaves, pumpkin leaves with Ugali in the rainy season. In the dry season no greens, we use meat for lunch and dinner.” I19, GI women Labarab

The same family explained that they had received only a small quantity of maize, salt, oil and lentils from WFP and that this was used up within three days.

For the pastoralists, it was clear that for a person to be healthy, s/he needs milk, however, in a context where people live close together, and lowland and highland Murle consider themselves as one and the same, highland Murle also appreciate milk as an essential part of healthy nutrition. In situations where food is scarce, highland and lowland Murle help each other.

In relation to food and nutrition, it should be added that in Naoyapuru, and even more so in Kassangor, high consumption of alcohol was mentioned. Respondents said that this was due to hunger:

“When you drink the local brew you will be satisfied, you do not feel hungry, if you lack food we drink more.” I39, elder man, Kassangor

One young man said, “the local brew is food”, which goes hand in hand with the fact that their cattle were raided in 2020. Loss of the animals meant loss of occupation and main source of income. As one leader put it,

“The problem is hunger, when there were cattle we were after cattle and did not drink, but now there are no cattle and we drink alcohol. Now we have nowhere to go, all are in the village, and even women drink alcohol.” I40, GI leaders, Kassangor
High alcohol consumption is accompanied by violence, which has been observed and experienced particularly in Kassangor and is discussed above in chapter 4.2 on the Jiye.

4.8 Sexual and reproductive health

Women’s sexual and reproductive health is central to the continuity of a family’s lineage and therefore it is vital to have healthy women who can give birth to healthy children. It was repeatedly acknowledged that a community can only exist when families have several children, to guarantee their security, survival and succession. After cattle raiding, when women and children were also abducted or after an outbreak of cholera or other diseases, women should get pregnant again to compensate for the loss.

"We are producing more [children] because we want to gain the number of people who died in the fighting and who were killed by the diseases." I5, GI women, Maruwo

"Since last year ten women died at birth, dead children are beyond 30. Since last year many kids have died of polio aburu; it has started from one family up to 3-4, beyond 200 kids have died of polio, because vaccination is not there. Now there are many pregnant women because they have lost many children last year.” I40, GI leaders, Kassangor

The significance of having many children was well explained in one interview, where women were seen as the capital of a family because they are exchanged for cows.

"Especially for us Murle some people can marry ten wives, fifteen wives because people like to have more children because we don’t have a bank account but we have cows so you have to marry if you want to keep the cattle… you have to marry a new wife and you pay with your cattle and this wife she can bring more children and those children someone can come to marry them from you, you give your daughter to someone and this one will pay you cattle back. It is like a business. Everything is about cattle exchanging.” I21, leader, Boma

4.8.1 Traditional SRH education

It was not entirely clear who educated the women in sexual and reproductive health matters. An older female relative or the mother might talk to the girls about menstruation and the menstruation cycle, behaviours in marriage and what to consider during pregnancy to protect the pregnancy, childbirth and delivery. For the girls to avoid pregnancy before marriage they follow their menstruation circle. It was said that the girls either learn this from their mothers or at school, at least in Boma.

"Because here they follow that one [the menstruation cycle]. They have experience, once they have attended the first stage of their period, they know how many days they have spent for each period. Some periods are different. You are calculating your days. From that one you know how long you are going to be on the period and when you can play with your boyfriend, and when there are the dangerous days. Girls who have gone to school learn about the menstruation circle. The ones who have not gone to school have learned from their mothers. The mother can tell her daughter this is like this and this is like that. So they teach them how to avoid pregnancy. If the girls is on the fertile period she will tell the boy that she does not want to have sex not to get pregnant.” I34, young man, Boma

When it comes to education about sexual intercourse it should be the husband who introduces his wife to reproductive matters. The husband also instructs his wife as to her responsibilities in the household, how and what they can eat, who are the husband’s friends and relatives, how to receive them etc. The husband tells his wife that the purpose of having sex is to ‘produce’ children. This is how it was explained in a paired interview with two young women:

[27 Most probably the ones in the same age-set.]
“We do not get any proper education until you get married, then your husband is explaining to you. I got advice from my husband. I was afraid for three days. Later I got advice from the husband and from the mother in law, within 4-5 days I felt safe with my husband.” I19 GI, women, Labarab

4.8.2 Personal hygiene

When girls get their first menstruation, elder women or the mother advise her what to do. They tell the girl that now she is a human being and that she will ‘produce’ her own children. Normally, women double or triple their underwear, or sometimes just use a piece of folded cloth. If a couple can afford it, the woman uses sanitary pads, available only in Boma. For personal hygiene, it depends on where the women live and how feasible and easy access to water is. When they live close to a river, women as well as men and children bathe in the river when they go to fetch water, either in the morning or evening, or both. When water is pumped from a borehole, it depends on how well this water point functions and how far it is from the homesteads. Whether women get enough water or insufficient water depends on the position and functionality of a pump. The situation is often more difficult in the cattle camps, and a bath can sometimes only be taken once a week, or even less frequently.

Before the first sexual intercourse, usually it is the husband who will ‘advise’ his wife. After sex, as water is a scarce resource the couple only wipe out the vagina with a piece of cloth; sometimes the woman cleans the husband’s penis, too. Among the Jiye, it is deemed inappropriate to bathe and ‘wash away’ the husband’s odour after sexual intercourse, as exemplified in the quote below.

In a discussion with healthcare staff in the Boma PHCC, I was told that some women deal with their personal hygiene in a different way, as deemed appropriate by educated healthcare staff.

“People here [around Boma] don’t like bathing, they don’t wash their private parts, the men don’t want the woman to wash because he feels dishonoured, the sperm should stay with you, inside you, so if a woman is taking shower to clean her private parts he [her husband] thinks she slept with another man. If the man was outside he is expecting you to smell like you smell when he had sex with you, if he comes back and don’t find the smell and sees that you have taken bath, he thinks that you had another man, he will have a question on you.” I32, GI health staff Boma

These are interesting features to consider to better understand how perceptions of personal hygiene and bodily practices can be aligned with recommendations made by healthcare staff. This also applies to childbirth, so as not to provoke marital discord in the broadest sense.

4.8.3 Pregnancy and childbirth

“For us traditionally the boys are the guardians of the home, they search for food and go for hunting and the girls are a source of wealth.” I2, TBA, Boma

Findings from other MSF reports in South Sudan (Bont, 2014; De Marez, 2009a) on the importance of pregnancy and numerous childbirths were confirmed by my research. Both women and men explained that children are of vital importance, and that it is best to have many children. Women should usually get pregnant within a few months of marriage. This expectation is not only expressed by the families but by the woman herself as well and therefore, people and women in particular are concerned about their pregnancy and childbirth. Many problems were mentioned in relation to pregnancy and childbirth, and these are described in the following section. It was said in the interviews that pregnant women are especially vulnerable and need special care but despite this acknowledgement, women had to work hard and could not take special care while pregnant. The Murle and Jiye nevertheless do have traditional ways to care for a women’s pregnancy and have some special rules and regulations designed to protect it.
The mothers and elderly women tell the younger women what to consider during pregnancy. Apart from physical and nutritional aspects, behavioural and moral rules are imposed on the women. Sexual intercourse is allowed until the sixth month of pregnancy; after this period the husband should abstain and is not allowed to engage with his wife until the child is weaned, which can be at the age of two. If the husband sleeps with his wife, it is thought that the semen can turn the breastmilk bad. However, in Kassangor women admitted that their husbands did not always respect these rules and engaged in sexual intercourse even while she is breastfeeding. Women in Maruwo explained about birth spacing and that the milk can ‘change’ and provoke diarrhoea in the breastfeeding child when the breastfeeding woman gets pregnant again.

“The child should be respected and given that time. You want to prevent another pregnancy. If you get pregnant again in a short period of time the child can die, because she [the mother] stops immediately breastfeeding, there is not enough food.” 14, GI women, Maruwo

The restrictions on sexual intercourse during pregnancy are not the same in all the areas. In Maruwo it was said that a woman could have sex with her husband, but if the woman were to have extramarital sex, she would break a taboo, leading to miscarriage. In Kassangor a woman explained that her husband would beat her if she refused sexual intercourse, even while she is pregnant. Women may want to refrain from sexual intercourse because they do not feel like when they are tired or not feeling well, or while breastfeeding, but their husbands did not accept these reasons.

Rules and regulations during pregnancy:

- Not staying in direct sunlight, as the heat could reach the child and cause miscarriage
- Not carrying heavy things, as the body’s blood could go downwards and push the child out
- Not eating the uncut intestines of a cow, as this could cause the placenta not to come out.
- Not sitting on a stone because delivery might take a long time and, since the stone is hard, it could push on the child’s head as the child turns downwards in the fifth or sixth month of pregnancy, or the woman could fall from the stone and hurt the child in her womb
- Not bending to one side while a woman sits as the umbilical cord could wrap around the child and the child will have difficulties coming out
- Not bending down as the placenta would move towards the foetus and block the breathing system of the child
- A pregnant woman should sit upright so that the umbilical cord does not wrap around the child’s neck
- A pregnant woman should not sleep on her back or on the belly but rather, on her side to prevent the umbilical cord wrapping around the child’s neck
- Not sitting on the wrapped cloth women use to carry heavy loads or water on their heads as the placenta could get stuck in the womb
- Sexual intercourse is forbidden after the sixth month

These rules and regulations also help women and the society as a whole to accept the occurrence of problems during pregnancy and childbirth because they provide an explanation of why they might happen.

After childbirth, Jiye women have to stay ‘indoors’ for one month and should not take the child outside to protect both her and the child from ill-health. Additionally, the mother is given cow’s blood to drink to replenish the iron lost while giving birth. The newborn’s mother is not allowed to fetch water or cook and she should not go outside to bathe, and someone brings her water instead. It was added that if the woman has relatives, they care for her but if the woman is alone, she is allowed to go outside. A Jiye woman can re-engage in sexual relations with her husband when her child is 6-8 months old.
In general, when the husband has been travelling and returns home, he is not allowed to sleep with his wife right away, as in case she had engaged in extramarital sex during his absence, it could cause either his, his wife’s or their children’s death:

“When he arrives, on the first day he cannot [engage in sexual relations], he can go the second or third day. It depends on the man how many days he can abstain. The man has to understand what was going on at home, he has to understand what happened in his absence. For example if his wife has committed adultery, he needs to find out from the neighbours, they will tell him; if that happened he will call his wife and ask her; if she was forced or if she has accepted, you go to the man [who slept with the wife], fight him and he pays 9-15 cows. If she was forced the man will be beaten and put to prison, traditionally this man will be tied on the tree and beaten by the age-set group of the man. Until he says what he has done. He has to say that he has done wrong and he has to ask for forgiveness. The wife will tell the husband ngicholai [this woman has committed adultery]. If a husband sleeps with his wife [who has committed adultery] he will die unless he slaughters a small sheep and pours the blood on him, his wife and the children.” I36, woman, Kassangor

Three main problems were mentioned consistently as occurring during pregnancy:

- Miscarriage
- Prolonged labour, up to 1-2 days, leading to the death of the child and sometimes the mother as well
- Discovering during labour that the child is in a wrong position which could lead to the death of the mother, the baby or both

Spontaneous abortions were mainly cited in relation to syphilis, but sometimes women admitted that they didn’t know what led to miscarriage.

“Miscarriage is very common, miscarriage is too much, it is so common, we don’t know which disease is encouraging this miscarriage. We have also a disease that attacks the head, the all head, it goes through the spinal cord up to the abdomen until you find that the sole of the feet is so hot. It attacks the waist and the abdomen and paralyses the parts.” I1, GI women, Boma

Most deliveries take place at home with the help of elder or experienced women or a TBA. In most cases, several women attend, but only three interfere directly with the woman in labour. The first woman or TBA to arrive is the one in front to ‘receive’ the newborn baby; this is the most prominent position and every midwife prefers this. Another woman supports from behind and a third is by the mother’s side.

![Fig. 19: Childbirth position Murle](image1.png)

![Fig. 20: Childbirth position Jiye](image2.png)

Usually, women deliver in a squatting position with the women supporting them both in front (Fig. 19) and behind (Fig. 20). The Jiye explained that the woman holds a trunk while giving birth. In one interview women explained what could happen if the parturient were to close her legs:
“We are not laying the woman down, we support her on the back, there are some women who fear the delivery, the reason of the support on the shoulders is to prevent her from moving too much and not closing her legs. The baby will die [when the mother closes her legs] it has no place of coming out, the reason for the child to die when the mother closes the legs is because it was the time for the child to come out it means the door is locked, so it will die. The child will receive fresh air, when the legs are open.” I22, TBA, Boma

When the child is in breech position or even in transverse position it is very difficult for the TBAs to do the deliveries. One TBA recounted that she delivered a baby in breech presentation for woman who had been turned away from the maternity unit in Boma:

“One time a child came in wrong direction and I could help this woman. I tried with my experience, I used my hands, I put them inside and stretched the hand of the child and then I stretched the leg of the child until the child was delivered. One woman was rejected by CARE to seek medical attention somewhere. I told this woman to come [to the TBA’s home], I will help her; the child was in wrong position, but we did the delivery.” I2, TBA, Boma

When the baby is born the midwife kneeling in front of the delivering mother is the one ‘receiving’ the newborn baby. She then ties the umbilical cord with a tiny white rope (Fig: 21), which is from a plastic bag of cereals, like maize or sorghum, which was unwoven to obtain the plastic thread. Once the umbilical cord is tied, it is cut with a knife (Fig: 21) or, when available, with a razor blade (Fig: 22). The midwife sucks the mucus from the nose and mouth of the baby and the remaining blood from the umbilical cord in order to prevent the baby ‘drowning’ in the mother’s ‘water’. The blood from the umbilical cord is spat on the ground and covered. When the placenta is out, it is spread out and all the ‘waste’ from the birth is put inside it. The placenta is then buried in a hole in the ground and covered, or, when the birth took place in a health facility it is thrown into the latrines.

The placenta has to be buried to protect the woman from curses; furthermore the placenta is considered as a human being.

“Traditionally the placenta is wrapped in a piece of cloth or plastic and behind of the house of a women you dig a hole and you bury it and cover it properly because if you leave it open it can be eaten by dogs and this woman will not deliver again and not conceive again – the placenta is a human being. We believe where your mother puts the placenta if someone takes the soil where the placenta was buried, this person has stolen the children that were supposed to be for this woman.” I1, GI women, Boma

The Murle explained that when the delivery is complete, they perform some ritual blessings for the mother and baby to protect them from ailments. When men visit the mother and her newborn baby, they have to be ritually purified as they could have been in touch with death.
“When the lady delivered, we take a charcoal we put it into the mouth, and we suckle it and spit it over the baby and the mother. It is a blessing for the baby not to get fever and the mother to deliver more children. When there is a visitor coming who wants to see the newborn before entering the house they have to touch the feet, the TBA is touching the feet, then the TBA is touching the breast of the mother of the baby not to cry, especially for men, because they used to move in the bush, they get fighting with other people, when men work in the bush and fight and kill others they should come home and stay alone before joining the family until they go to the bush with the Red chief to make a fumigation with special herbs, water and a spear; from there the man can come back home; they don’t know where the man is coming from, when touching the feet you can neutralise what the man has done.” I7, GI TBAs, Maruwo

The baby’s navel is disinfected and treated with ‘lulu oil’.28 The child receives a name in line with the financial resources of the family. As a sign of appreciation, the child may be named after the woman or TBA who has delivered the baby if it is female, or alternatively, it may be named after the grandmother or grandfather. Sometimes it is only given a name three weeks or even two to three months after childbirth, when the family has gathered the needed resources.

“It depends with the resources you make a naming ceremony. You call people to witness the ceremony. 4-5 months then you make the ceremony. If you don’t have money you name the child after any relative or friend, or after the TBA.” I4, GI women, Maruwo

4.8.4 Infertility

The significance and importance of having many children

For the Murle the only really dead person is the one who dies without children. Any dead person is only physically dead, but the spirit remains and becomes an ancestor who cares for subsequent generations of relatives. Therefore, people also have to care for their ancestors, as otherwise they can make them sick.

The question of infertility is a vital concern, for which ‘creative’ solutions are found in both the Jiye and Murle communities. The most important objective of such solutions is that a person’s linage does not end with the death of the person, and that no-one should die without children. In the Jiye populations, an infertile woman is given children by other wives of the husband, whereas among the Murle, the husband might marry another woman who bears children in the name of the infertile woman and the children born are considered hers. If the man is infertile, he might ask his brother to sleep with his wife, or, if his wife is very young, he may ask his oldest son to have sexual intercourse with her. The children are considered to be the father’s children and to continue his lineage. Others said that a man may ask his wife to find a solution ‘outside’ in secret, meaning she should look for a lover, and the children born are considered her husband’s.

Since pregnancy is the expected condition of a woman, the absence of it is reason for concern. As discussed in the chapter on the ill-health conditions of men, they do struggle with infertility due to sexually transmitted infections. Syphilis was mentioned in all the interviews and seems to be the major problem that men and women refer to when addressing their main health problems; in the worst case scenario it leads to infertility on the woman’s and/or man’s side.

Syphilis is seen by the Murle and the Jiye as one of the main causes of infertility. In their perception, syphilis is widespread. Among the Murle, a woman without a child is called awo kolin which literally means ‘moving without child’. This is perceived as an insult and a woman does anything she can to avoid such exposure. As

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28 The shea nut tree is known in Arabic as Lulu tree.
previously mentioned, creative solutions are available to avoid being discovered and regarded as infertile on both sides, men and women:

“You look for another wife to produce children, sometimes you can ask this other wife to give one child to the one that is not able to have children. They can give only one child. If you have three wives, the other one can give also one child to the barren one, then that’s all. If the husband is impotent you ask your brother to sleep with your wife, outside your house, until she gets pregnant, then he stops.” I33, Jiye man, Boma

It is even a concern if a woman has already had some children, is still of childbearing age and wishes to have more children:

“When the woman is older and the marriage had already other children, her son will marry and the children born from this marriage will be considered for the older woman [his mother]. Her son will marry this woman only to reproduce for his mother. But he [her son] will marry his own wives which will reproduce for him.” I11, Gi CHW, Maruwo

In a group discussion with two elder women in Kassangor they talked about abducted children and a specific transaction between the Murle and the Jiye. They said the Murle would sell abducted children to a Jiye woman if she is infertile and explain how she feels in her community when seen as barren:

“There are women that have never delivered since they are married. Only God knows the reason. Murle will sell abducted children to a woman without children. Sometimes in the community if she [woman without children] asks her co-wives’ children to get water for her and you insult her for that she will not feel ok.” I37, Gi women, Kassangor

4.9  Meaning and perception of death

For both the Murle and Jiye a dead person is not considered dead and therefore death is not announced in the community. A dead person becomes an ancestor with whom people stay in touch throughout their lives. People believe that a person continues to exist after death, they accompany the living ones and can influence their well-being. The spirits of all dead people are thought to live in the river Giro.

Death is considered an impure matter that can harm the living. This is why people who have been in touch with dead bodies, or persons who have killed somebody have to undergo some purification. This is when people explain their fear of death and dead people. In the interviews, it was also explained that when men come home from the bush, they have to purify themselves before entering the house of a woman with a newborn baby, as it is not known what they have done while they were in the bush, i.e., they may have killed someone. People do not want to see a dead person; the dead body is buried as quickly as possible and only by men. Women are generally not part of the burial at all. Some years back, when someone died in a cattle camp, the people abandoned the place and migrated somewhere else, as the place was considered to be polluted. The dead body was not buried but left in the hut the people had abandoned. But nowadays, with the adoption of some Christian rituals and modern concepts of hygiene, most people are buried.

Among the Jiye, death is also something considered impure and is something people fear. As explained in respect of the Murle, only men should deal with a dead body and only men bury a dead person. The body should be buried with the head facing north. People prepare a kind of bed with sticks, put the dead body on it and put it into a hole that was previously dug. For women, beads are put on top of the grave; if she were buried with the beads it would mean that she is still alive but if the beads are removed it means she has lost her body. The beads are later taken from the grave by elder women.29

29 Supposedly, by elder women from the same age-set group.
4.10 Healthcare options in the GPAA

Traditional versus modern approaches to sickness and healing

The main difference between traditional and modern approaches to sickness and healing lies in the perceived cause of a health problem: Modern medicine concentrates on the human body while traditional medicine concentrates on forces outside the human person, which came to disturb their physical well-being. If we keep this in mind, we can try to better understand our patients’ approach in terms of looking for a cure for their suffering.

An initial glance at the healthcare situation in Boma county is provided in chapter 1.3., including details on how many facilities are available/functional, with an indication of walking distances to Boma centre, where the only PHCC is located.

Available healthcare options:

- **PHCC in Boma** (supported by CARE)
- **Private clinic** at Boma market, not really mentioned as a viable option
- **PHCU** in Labarab and Naoyapuru (Labarab not functional)
- **Community health workers** (CHWs) – no formally trained and appointed CHWs were met; two nurses who had previously worked with MERLIN in Boma called themselves CHW for lack of other vocational opportunities and to serve their communities
- **Traditional birth attendants** (TBAs) – TBAs were said to be almost nonexistent if a TBA is understood to be a woman experienced in helping women in childbirth, who has received some training from the MoH or from NGOs
- **Traditional healers** (TH) – include those who perform divination, those who perform rituals and treat the person through spiritual and performative means (Scott et al., 2014) and those who join broken bones and apply herbal treatment.

Apart from these options, and only when an ill-health condition is considered very serious and only during the dry season, people travel to Kapoeta to a second-line hospital, or alternatively, they go ‘outside’, meaning travel to Ethiopia to access healthcare there.

4.10.1 PHCC in Boma

The PHCC in Boma is seen as the hospital in the area which is accessible in case of serious ill-health conditions when people live further away, like Maruwo, Labarab and Kassangor. For people living in the surrounding villages, like Nyat and Naoyapuru, Boma is accessible even during rainy season.

“Sometimes we go to Boma, we carry the patient, we lose many people here on the road, walking to Boma in rainy season it is three days, in dry season two days. You need to walk with 6-8 people; if you have many relatives you can go, if you are only three in the family you cannot go. But if you go to Boma there is nothing with CARE.” I3, GI leaders, Maruwo

Boma PHCC is lacking in drugs, materials, supply, services, and human resources. People have little trust in the healthcare staff, medications prescribed, and healthcare services provided. Boma PHCC is perceived very negatively and CARE support is neither valued nor appreciated. Rather, it is constantly being compared to the service that had previously been provided by MERLIN, which is thought far superior. We will discuss Boma ‘hospital’ (PHCC) further in the section on health-seeking behaviours.

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30 We will still use the term TBA in this report, as it refers to women who have knowledge in childbirth.
4.10.2 Private clinic in Boma

The private clinic in Boma was said to be only for people who have money. The few that mentioned the private clinic were satisfied with the services there, as tests are done and medication is provided, but at a high cost and therefore not available to everyone. Some respondents said that when the hospital lacks drugs, they send patients to the private clinic to get medicines from there. The private clinic was said to mainly treat syphilis, which requires a treatment worth almost the cost of a cow.

“If you do not get treatment with CARE you go to the private clinic. I saw the private clinic, he is injecting, people and said he is a doctor. One injection is 10.000 SSP [20 USD], the private clinic is mainly treating the dolach. He gives five injections of Sofrasol and you pay 50.000 SSD [100 USD]. For that you can sell one cow.” I20, leader, Labarab

4.10.3 Community health workers

Unfortunately, we did not encounter any formal system involving CHWs in the areas visited. However, it was understood from informal discussions that CHWs did exist at some point in various locations, as one of our drivers explained that he himself was once a CHW in Labarab. As previously mentioned, two self-appointed CHWs served in Maruwo for lack of other job opportunities as nurses. CARE is starting with the Boma Health Initiative, which includes CHWs in Naoyapuru and Ngalangoro.

4.10.4 PHCUs Labarab and Naoyapuru

In Labarab and Naoyapuru, PHCUs were said to be available but when we tried to visit the PHCU in Labarab, the tukul was not functional. It was also mentioned that it was not an option for healthcare provision as it lacked any supply of drugs. The only healthcare option available was self-treatment and treatment from a traditional healer, unless people went to Boma or elsewhere. In Naoyapuru, which is much closer to Boma, the PHCU seems to have an inconsistent supply of drugs and people went to this establishment, but are also confronted by a lack of medicines there. Women said that this PHCU only treats malaria, fever and cough.

“We go there when we are sick, even with syphilis we go there to confirm if you have it. But if we go to the PHCU, the doctor tells us there are no drugs, so we just remain here.” I30, GI young men, Naoyapuru

During a visit to Nyat it was understood that people have access to a PHCU supported by CARE. People can get treatment for malaria and medication like Paracetamol and Amoxicillin for chest and breathing problems, and ORS for watery diarrhoea.

4.10.5 Alternative healthcare providers – TBAs and traditional healers

The different types of healers (ngari or arit for the Murle and amuron for the Jiye) can be categorised by the specialisation, treatments and services they provide, the methods they use to apply treatments, and the skills they possess. During our fieldwork, we heard about three types of traditional healers. There are those who do divination to find out if witchcraft is involved and where to treat the sick person, and those who perform healing rituals during the night. These two are called, respectively, ngari or amuron which translates to “witchdoctor”. Additionally, there are those who apply herbal treatments to join broken bones, called arit.

“If I want to go to the amuron, we have two types of amuron: 1: This one can check the witchcraft; 2: The other one uses the skin of animals they clap on it and they speak about the problem and they ask the oracle, the sound of the skin; from there she can tell you who is the one who cursed you, and what

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31 It was not clear if it was really a PHCU but people called it that in the interview.
can prevent your sickness; you look for a goat or a sheep and you make a sacrifice and you will feel better and then you can go to the hospital.” I39, elder man, Kassangor

Divination sessions are performed in two different ways, either reading in ashes (Fig. 23) or sand, or in clapping sandals (Fig. 24) or in two leather pieces on a mat, throwing them down and reading from the position in which they fall.

The Murle also have whom they call the arit, which is translated as ‘a gifted person’. This can be a traditional healer who applies herbal treatments or joins broken bones, or TBAs who assist with childbirth. Some healers were praised for the treatment of fractures and were said to be good at joining bones. The Murle traditional healers, the aritnya (plural), treat certain diseases by giving herbal drinks or performing incisions on the skin, into which they rub plant powders or ashes. When they think that witchcraft or curses are involved, a healing ritual with the ngari or amuron has to be performed, which takes place during the night. In Boma it was said that when MERLIN was there, people went to the hospital, but since MERLIN left, people have been going to the traditional healer. In Labarab, a ngari said that all ‘paining’ conditions are caused by a curse, as the patient feels something burning or running inside the body. Another ill-health condition for the ngari is swellings, and she acknowledged that she does not treat syphilis, typhoid or malaria. These diseases should be treated at the PHCU. She also said that now, elder people tended to believe in the ngari, while the younger ones preferred the PHCU, but added that she treated around ten people a day.

For the Jiye, those who find out what caused the disease talk to the God akuju, who tells him or her in a dream what or who has caused the condition of the person he or she is treating. Then that person is treated by the other amuron in a ritual or performance in which the witchcraft is extracted from the body. This is done in a very performative way with a lot of movements and gestures by the amuron, who has to show and prove his/her power in finding the ailment. Sometimes the amuron extracts an object from the body and shows it to those present, to underline that the witchcraft has been defeated. The sick person stays with the traditional healer until they are cured. The payment for the amuron is a goat or money in the amount of 10,000 SSP (20 USD).

The graphic shows how the healing ritual is organised; the pink circle symbolises the cow hide on which the patient lies. The following account explains such a ritual:

“They put a cow skin on the soil, they lay the patient down [on the skin] and beat the skin to make noise, for the amuron to be active, the crowd of people will beat the skin of the cow, the crowd is around the amuron, dances and sings, the patient sits in the middle, the amuron approaches the patient, touches the patient, she is singing and touching the patient, we don’t know what she is doing. The circle of the crowd is open and there is a fire, she goes to the fire and back to the patient, back to the fire. She is not showing
or saying anything until the person becomes better. This performance can take several days or even one week or one month. Sometimes the patient can die during the performance so the *amuron* did not help or the disease was too serious so that the *amuron* cannot treat. The *amuron* takes something from the patient and puts it to the fire to kill it. Also an infection, she takes [out]and puts it to the fire. Sometimes the *amuron* says the infection is also affecting her the *amuron*.” I30, GI men, Naoyapuru

Fig. 23: healing ritual performed by an *amuron* or *ngari*

**Becoming a TBA or traditional healer**

Acquiring knowledge through the family is the most common way of becoming a healer. The few healers I was able to talk to said they had learnt their craft from a parent, either their mother or father.  

“I have learned it form my mother, the way I became a witch doctor is my mothers was a witch doctor. My mother died, I worked with my mother, she was teaching us.” I12, traditional healer, Maruwo

It was not mentioned if they also received knowledge directly from God or from ancestors through dreams, but during their divination and healing performances they all said that they refer to God as the acting power between themselves and the patient and their family. The traditional healer I talked to stated that God is helping her in her work, meaning also to cure people.

With the Murle, a TBA is called *ngai chi agam dol* which literally means ‘women helping in delivering’. TBAs said that they have become a TBA through experience, ‘doing’ deliveries within their families and their neighbourhoods.

“We don’t have any training, we do [the delivery] traditional, we copied from our mothers, we did like our mothers, we observed them.” I7, GI TBAs, Maruwo

Most of them stated that they started within their families, with only one adding that if it is a difficult delivery with a breech position she would do it only for a relative but not for other people in the village because of the risks involved. In a group discussion with leaders, it was said that TBAs would only help within the family as people could not afford to pay them.

“So here is no TBA [trained by an NGO], when there is a childbirth you can help only your relatives, because there is no pay, so she is only supporting the relatives.” I40, leaders, Kassangor

**Payments**

When it comes to payment, all the TBAs I talked to confirmed that they did their work for free. Only if people wanted to show their appreciation did they give them some food, soap, maize, or a goat or sheep. A non-monetary form of appreciation was to give the newborn the name of the TBA.

“What can you receive for helping in delivery?
We get nothing, we are just volunteering, the only thing is they can give the child the name of the TBA. The reason to give the name is to be remembered, that this child was delivered by this TBA. The child is named after Alyssia, this child is delivered by Alyssia, the child was waiting for Alyssia to come.” I7, GI TBAs Maruwo

Not much information could be gathered from the traditional healers, but in the interviews, it was indirectly mentioned several times that a traditional healer would also expect money. One example was given by a young mother who was not getting pregnant anymore after she had had a difficult delivery. Since she could not access medical care in Ethiopia or Kapoeta, she suspected that someone in her family had cursed her. But because of lack of money she was also unable to consult a traditional healer:

“Even this ngari needs money, so how should I go there. Where will I get these things. It depends on the ngari [how much you have to pay], 10, 15, or 20 up to 30.000 SSP and above.” I23, young women, Boma

4.11 Health-seeking behaviours

As with many other contexts, the decision of where to go for treatment is not an individual decision. In most cases, it is taken either by the family or by the husband of the woman who is sick, or whose child is sick. In the case of a sick child, he is either informed by his wife or, in his absence, his father or mother can take the decision of where to go. If the husband is absent, which is quite often the case, the mother-in-law has a crucial role to play when it comes to navigating healthcare options. This is especially the case when financial matters are involved, as the woman is dependent on the support of her husband.

What can generally be acknowledged for all places visited and both ethnic groups is the differentiation between diseases that should be treated in a healthcare facility and disease that can be treated with a traditional healer only. As previously mentioned, the health-seeking behaviour is also greatly influenced by the presence of Christian missionaries in the respective areas, who condemn traditional healing and healing rituals that deal with witchcraft and cursing. Areas that have not been converted to Christianity are Labarab and Kassangor.

It is also understood that in most of the places visited, no drugs can be obtained from either a market or chemist or pharmacy except in Boma, where medicines can be purchased at the private clinic of the Ethiopian owner. In Maruwo market, Artemether ampoules and a tablet strip (Fig. 25) was discovered in one of the shops.

Fig. 25: Artemether and a strip of tablets

32 Our medical doctor for the assessment Alyssia, while working at the mobile clinic, attended a delivery; the baby (a boy) was given her name.
The following account from Kassangor may be also relevant for most of the other contexts, except perhaps Boma, where drugs are available at the PHCC. A mother recounts the story of how her child had died:

“The child got sick, it refused to breastfeed; then there is no medicine to give to the child, there is no clinic to go to. Then you look for the local traditional medicine, we use the leaves of the neem tree and gave the child to drink, but it did not help, there is nowhere you can take your child. Then I went to the amuron. The amuron made her own work and then from there I have nothing to do for my child.

Sometimes the illness will kill the child because you have problems with your parents, and they will curse you. The amuron can take the witchcraft from your body, but for other illness, like fever, diarrhoea, cough, chicken pox, the amuron cannot treat it. Sometimes the child has a problem then you go to the amuron, but then the amuron tells you there is nothing I can do. The amuron is looking to the ashes and says this child I cannot treat. When I went to the amuron, she said that she cannot treat the child. Then I went back home, and the child died.” I36, woman, Kassangor

For this woman it was not an option to go to Boma or elsewhere to treat her child and there could be a variety of reasons for this, financial, practical, environmental or the fear that if she were to go to Boma, the child might die on the way there or treatment might not be available. These possibilities are considered too risky to engage in the journey.

The value of a sick person

In contrast to many other social contexts in Sub-Saharan Africa, in this area of South Sudan, a sick child is valued more than a sick adult. It was explained that a child needs to get cured in order to become an adult, so as to be able to give birth to many children; an adult has already delivered children and can go (die).

“If the mother is sick and the child is sick, I prefer to treat the child first, the child is small and needs treatment to get big and get an adult. I am already an adult person and I have delivered my children already, so if I die I leave my children behind. In Murle tradition when you have your children and you die you leave your children behind, your children can grow up and have their own children and your name is still remembered for a long time. That is the reason to first treat our children”. I9, GI TBAs, Maruwo

This quote again supports the importance of giving birth to children and to care well for them so that they can grow into adulthood and continue the lineage.

4.11.1 Popular knowledge about herbal treatments and self-treatment at home

Alongside the specialist knowledge which traditional healers have acquired throughout their lifetime, there is vast popular knowledge of various medicinal plants for different ill-health conditions. For lack of other options people do fall back on their own herbal knowledge a lot and they collect and fetch herbs to treat their ailments. Even in Boma, where the PHCC is within reach, women recounted that they did not go to the hospital because they knew that nothing was done for the child there. Instead of going to the hospital, they use leaves from the neem tree to treat malaria, and aloe vera to treat yellow fever. The women had learnt from health promotion sessions held by MERLIN that they can give water with sugar and salt when a child has diarrhoea. The same practices apply to other locations, like Maruwo, Labarab, Nyat, Kassangor and Naoyapuru. In Labarab, people said that they also used hot pepper to treat malaria. They first applied self-treatment, using medicinal plants they know; only in a critical situation did they refer to a traditional healer, though it transpired that this is rarely the case in Maruwo. In Nyat and Labarab, it was added that it was the men who usually went to fetch the plants; only when the men were not around did the women go to get the plants themselves. In Labarab, people said that when the herbal self-treatment did not work, they went to Ethiopia if the disease was serious.
“We go for herbal medicine, the bitter ones until we get better. We do not have aritnya we just try any bitter leaves and barks. How do you know how to treat it? We are just trying; the only option is the trees we have; we search in the bush the bitter leaves, boil in water, take the liquid put it in a syringe and put it into the anus of the child [to treat chuguk]. Sometimes it helps but many die.” I3, GI leader, Maruwo

Plants are used in the form of leaves, barks and roots and either pounded to powder, burnt to ashes or made into a decoction to drink. Sometimes, plant powders are directly applied to the wound or mixed with water and then drunk.

In most interviews, people acknowledged that they were tired of using herbal medicine as it did not cure their diseases. Sometimes it helped to alleviate certain diseases, but in general it was said not to help.

“It [herbal treatment] helps for 1-2 days but then it [the disease] starts again, it cannot cure. It kills people when you cannot treat, as it goes into your stomach and you can die.” I27, GI young men, Nyat

For the people living in cattle camps it was recounted that they used herbal treatments and sometimes did have a person with specialist knowledge in the use of plants with them.

“These people [in the cattle camp] have their traditional doctors that can heal, they take the wild leaves, they soak them and then they drink them, and they can heal. Not only in the cattle camp even for all Murle lowland and highland they are also using that one. The person who can give you the healing trees is called arit and this is a wise person, it is a gifted person. It is not the ngari because the ngari is the witch doctor. Here [in Boma] the witch doctor is not so much used anymore only a few people. It is the people who are not going to church who still go to see the ngari.” I34, young man, Boma

One additional self-treatment was mentioned that does not involve plants. To treat chest pain, people in Naoyapuru explained that they either tie a rope around the chest so as not to have pain when they cough, or that they heat an axe in boiling water and put it on the chest to reduce pain through warmth.

4.11.2 Traditional healers and TBAs

As explained earlier, different types of traditional healers are available and the belief in the effectiveness and efficiency of their practices differs considerably, as seen in the chapter on available healthcare options. Traditional healers are consulted when people think a supernatural force is involved in the illness, like curses or non-compliance with a taboo.

In Boma and Maruwo, the traditional healer does not play an important role anymore. In Boma, a traditional healer is considered only for the worst cases, when people do not see any other possibility to treat a sick person anymore. In Maruwo, respondents said that people did not go to the traditional healer as these were useless:

“We realised these witchdoctors are useless, they only predict but they don’t say the truth. Sometimes they guess.” I5, GI women, Maruwo

One female traditional healer in Maruwo33 explained that she helps women when they cannot conceive children anymore. She said that in ten years, she cured ten women from sterility. When a woman has difficulties in childbirth, she massages the belly to encourage a quick delivery.

In Labarab, the situation was quite different. Elderly people do still consult traditional healers and witchdoctors to perform healing rituals.

33 The translator, who was from Maruwo, said that women did not consult her anymore.
“Here in Labarab the old ones they want to see the traditional healers like ngari, the young ones it is very rare.” I15, GI women, Labarab

People consult traditional healers mainly for non-natural ill-health conditions, which could be swellings, paralysis, etc. In Naoyapuru, the problems with which people go to see an amuron are paralysis, mental problems, when a person is just running around and screaming, not eating, or when the body is in a ‘coma’.

In Kassangor, people explained that they first tried to find out what has caused the ill-health condition and therefore went to the traditional healer, especially to find out if witchcraft is involved or not.

“We go to the amuron (traditional healers) for check-up, to know if there is witchcraft or not.” I39, older Jiye man, Kassangor

Answers in Kassangor were a bit mixed and at times a bit confusing as well, as some said the first option is the atalya = Western healthcare facility, while others said that first the amuron had to ‘check’ if witchcraft was involved. If it is not, then the disease needs to be treated by the Western healthcare facility. On other occasions, women said that there was no need to use traditional medicine, such as preparing leaves, roots or barks soaked or cooked with water and drunk, or other herbal treatments applied to the body in case of wounds, skin infections and rashes, if there was a healthcare facility available. It was said that even the amuron her/himself would go to the hospital.

People living in cattle camps access healthcare through traditional healers and self-treatment rather than seeking out a facility. When they are close to a place with a Western healthcare facility, they do draw it. In another conversations, it was stated that people living in cattle camps have access to financial resources because they could sell a cow to get money, and during the dry season they could also more easily reach a healthcare facility.

“The cattle camp people can sell a cow and can get money to get treatment elsewhere.” .... During the dry season, we have more women to deliver they come back from Ethiopia from the refugee camp and from the cattle camp to deliver [at Boma PHCC].” I25, Gi MoH staff, Boma

4.11.3 Formal healthcare facilities – the PHCCs and PHCUs

When talking about people’s experiences with ‘formal’, ‘Western’ or ‘professional’ healthcare facilities, we also have to address the differences that were experienced in healthcare provision at the PHCC in Boma, which people referred to in respect of the hospital being initially supported by MERLIN and subsequently by CARE. Listening to people’s accounts in the interviews, it quickly became clear that everybody praised the ‘old times’ (2008-2013), when MERLIN was present in Boma, while they were highly critical of the performance of CARE.

“Theyir work is like 0.1%, nothing is given, in the health centre there is no paracetamol, there are no services. They send the mothers to the private clinic and if you don’t have money your child will die.” I2, TBA, Boma

In all the interviews and in all references made to Boma and the current PHCC, only negative comments were received. Complaints were made that CARE ‘gives nothing’ and that when MERLIN had been there ‘all was good’.

34 I would just like to pay attention to the ethnocentric view of these expressions, as a traditional healer or TBA might also consider him / herself as professional; it is a question of perspective.
People stated that they were tired of CARE, that they wanted CARE to leave and not extend their contract. Even the medical personnel working in the PHCC complained:

“CARE is doing nothing here. When we have no drugs, the people are just suffering. When some people have the money, they go to Ethiopia by footing [walking] to buy the drugs there. Some go to Kenya to get treatment there. If you are poor, you just stay and most of the people don’t have money.” I25, Gl MoH staff, Boma

By contrast, it was observed that MERLIN had employed qualified personnel, including for overnight stays at the hospital, that referrals had come from Labarab, Mewun and even from Pibor, and that childbirth had also worked well. It was recounted that ‘all women went’ to the PHCC to give birth; only in emergencies or when labour had started at night did women deliver at home. In a group discussion with women in Boma, the clinical officer James Kaka was praised, since “he still prescribes drugs that can cure you”. However, we also know that he was a former MSF employee from Pibor who had been dismissed because of alcohol abuse. People emphasised that he was never drunk in the morning and that he visited people at home when they were sick. One woman asserted that “the best option [in Boma] is James Kaka”.

People walk to Boma from Maruwo, Labarab and Kassangor,35 but are hesitant to engage in such a journey. Boma is an option and yet often, it is not. People can walk but it is very far, and they might arrive only to find that there is no treatment because the required medicines are not available. And they risk dying on their way to Boma, either because they are too sick or because of insecurity, as people from Kassangor stated. People only travel in larger groups, as they fear being attacked by Murle or Toposa. Many also mentioned that deaths on the road to Boma are frequent:

“Normally people are afraid to go alone to Boma, so they go together in a group. We go together with ten or more people. We fear road ambush from Murle and Toposa. They just want to kill you because you are not a Toposa or not a Murle.” I36, woman, Kassangor

In the case of Kassangor, even when people said they regarded the hospital as their last option, it was also understood that it is often not possible because the hospital is too far away. When they have no other means to treat the ill-health condition, they revert to self-treatment with plants or consult the traditional healer. It was also added that they could possibly reach the Boma hospital with a sick person, but not with pregnant women, as pregnant women could not walk a long way, and Boma is too far anyhow if problems arose during childbirth.

Before MERLIN left Boma in 2013, people from Maruwo and Labarab went to Boma but now preferred to go to Ethiopia for healthcare. Since the borders have been closed due to COVID, they have had to refrain from going to Ethiopia and are dependent either on Boma or on self-treatment.

“Because there is no medicine, no tetanus vaccination, the majority is not going [to Boma] because of the distance. Unless you have a very important issue you can walk, e.g. buying salt and oil or bringing sorghum for your relatives or for diseases. If the pregnant woman is able to move, she can go. If you go you need to have a group of people because of security. Now there is peace, but we fear the Toposa and Murle. They may attack you because you are the enemy, you do not belong to that community. During rainy season you can reach Boma, but you will be tired. The biggest problem is during rainy season for the sick person not to reach well Boma, so you might die on the road. Many people are dying on the road; ten were dying last year; last month three men and one pregnant woman died on their way. The relatives took them with the donkey, but they died on their way. One man had headache and he fainted, the other had difficulties in breathing, difficulties in eating and drinking, one had cough like TB.” I38, Gl young men, Kassangor

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35 Walking time to Boma: from Maruwo 11hrs, from Labarab 3 days, from Kassangor 14hrs
Conditions that are considered very serious and longer-lasting were, among others, lower abdominal and back pain, symptoms referring to syphilis, coughing, difficulty breathing or chest pain that was related to TB in adults. But as mentioned previously, such travel also involves financial burdens.

“No now you have a woman with dolach [syphilis] where do you take her? For example she stayed for 4-5 years after marriage [without giving birth], first she goes to Boma, then to Ethiopia, or to Juba if you have transport. For the lady to be sent to Juba, it is with the commercial flight, we can send her when we have money; we give 3-5 cows. For Ethiopia we start footing [walking] up to South Sudan’s border then we take a vehicle, and we also pay with cows.” I9, GI TBAs Maruwo

In Labarab, people greatly appreciate formal healthcare but it was clear that if the cause of a condition was thought to be found in supernatural forces, they would go to treat it with the traditional healer. In Nyat (2.5 hours’ walk from Boma) people explained that Boma was not really an option because there would be no drugs or treatment, so no need to walk to Boma. People complained that the hospital only provides ORS when their child has diarrhoea and for malaria treatment; the infusion was considered to be just water, so not an appropriate treatment.

“We can go to Boma when the child is sick or if myself, I am sick. When the child is very sick, and the child starts convulsing and the body is shivering with high temperature and the baby has continued watery diarrhoea. But when we go there, the only medicine we get is ORS.” I28, women, Nyat

In the interviews conducted in Naoyapuru, the hospital in Boma was not mentioned as an option because people said that if they went there, they did not receive any good medicine. The same was said for the PHCU in Naoyapuru. People said they might go there to have a diagnosis of syphilis confirmed, only to hear that no drugs were available. As in other locations, people emphasised that when MERLIN had been in Boma they used to go there.

“When MERLIN was in Boma we went there but when MERLIN left, we stopped going there.” I31, GI women, Naoyapuru

Going ‘outside’

People frequently mentioned ‘going outside’, meaning to go to a place outside their village and beyond South Sudan. ‘Outside’ meant to leave Boma county to get treatment in Kapoeta or in Ethiopia. Whereas Kapoeta cannot be reached during the rainy season, it was underlined that people could still walk to Ethiopia. Ethiopia was constantly mentioned for good treatment:

“To go to Ethiopia, you need money. Two years back people went to Ethiopia for any treatment, syphilis, TB, STIs, asthma, they also take the children with malaria, diarrhoea, RTI, watery and bloody diarrhoea. Now the borders are closed because of COVID. You foot [walk] to Raat, it is the border, you walk four days, from there you hire a car.” I11, GI CHW, Maruwo

4.11.4 The private clinic in Boma

The private clinic that opened in the Boma market recently (in 2020) is only an option for people with money. Further, it was observed that even the private clinic sometimes ran out of drugs.

“In the market we have only the private clinic, this clinic needs money so if you don’t have money you don’t get anything. Our complain is to the hospital, the person who is in charge of the hospital is for everyone, if you have money or not it can help everyone, but for the clinic you need money.” I23, GI young women, Boma
During a visit to the private clinic with the objective to meet and talk to the responsible person, we encountered a considerable number of patients waiting for treatment. One woman had just been injected when we arrived there. The minimum which people spend at the private clinic is 10,000 SSP (20 USD).

4.12 Factors influencing health-seeking behaviours

Health-seeking behaviour is influenced by many factors which interfere, overlap and often vary within the same family during ill-health. Given the scant healthcare system that exists in the GPAA, how do households navigate the available options, and what factors influence decisions?

Concerning the findings of this assessment, we argue that volatile and harsh living conditions are the main reasons that influence people’s access to healthcare. These are, first and foremost, the availability and accessibility of healthcare. Disease interpretation and explanatory models play only a secondary role, as traditional and complementary medicine is used when other healthcare options are simply not available, which means in most cases that people cannot chose where to go for treatment, but have to make use of what is available, and that is plants and healers.

As observed and experienced in other contexts, people self-medicate at household level before seeking further care. Depending on the perceived characteristics of an ailment, and often directed by ‘important others’ such as husbands, mothers-in-law, parents, relatives or neighbours, help is sought in the village, either from within the family for self-treatment, from a traditional healer, or from a PHCU if available and functioning. If an illness still persists after treatment, the anxiety and desperation associated with it also grows. This can and often does lead a patient or caregiver, and his/her other influencers, to try options that are more difficult to access, like the PHCU in Boma or ‘outside’, in Kapoeta, Juba36 or Ethiopia. In this way, biomedicine, traditional healing and self-treatment often become intertwined – serially or concurrently – during ill-health. However, the majority of people revert to self-treatment with herbal remedies. In the following, we will outline six different areas that influence health-seeking behaviours. None of them stand alone; all are intertwined.

Health-seeking behaviour in such a context is guided by several interrelated factors, which form a complex net of determinants. According to Hausmann-Muela (Hausmann-Muela et al., 2012), these can be put into four categories. We have slightly modified this model and added a fifth and sixth category to consider perceived quality of care and prior experiences with other healthcare providers, to better fit the findings and analysis of those in the assessment area. We structure these factors according to the importance they played in the assessment area.

4.12.1 Access to healthcare

As previously mentioned, people in the various locations of the assessment area have little choice when it comes to accessing healthcare. Either no health facility is available or facilities are too far away, like in Boma, Kapoeta and Ethiopia, and are therefore either inaccessible or unaffordable (financial resources, means of transport, rainy season, etc.).

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36 Juba was mentioned only in one interview, as it involves high costs and a flight.
Affordability plays a role when it comes to financial and economic aspects, including additional associated costs. Costs associated with a visit to the PHCC in Boma, or a hospital in Kapoeta or Ethiopia, include travel and lost time:

- **Travel costs:** If the PHCU or PHCC is not located within the community and requires long-distance travel, it becomes much more expensive for local people.
- **Lost time:** Travelling to a PHCC takes substantial time away from other tasks, such as cattle herding, farming, cooking, caring for children and fulfilling household tasks, etc.

### 4.12.2 Illness perception and explanatory models

How the causes of an ill-health condition are perceived determines whether the disease is treated with a traditional healer, *ngari* in Murle and *amuron* in Jiye. Before people decide where to go and how to treat a condition, they first search for the cause of the disease, and only then agree on which healthcare provider to approach for treatment. This decision may change later if the expected cure is not achieved. People also evaluate the severity of a disease, how long the person has been suffering and how susceptible the patient might be before navigating the healing path.

> "If I am sick and I don’t know what I am suffering I call for witchcraft, if it was long with me, if I do not recover, I call for the *ngari*. Normally they use local medicine, they go for the leaves themselves, if it does not help, they are calling for witchcraft." 116, GI leaders, Labarab

Arthur Kleinman’s concept of explanatory models (EM) describes how patients and caretakers, their family and health practitioners interpret a disease. Explanatory models characterise an episode of sickness and its treatment. They are employed by all those engaged in the treatment process (Kleinman, 1984). Examining patients’ and their families’ EMs conveys how they make sense of episodes of illness – the cause and course of a disease, and how they choose and evaluate particular treatments.

### 4.12.3 Decision-making and social values

Therapeutic choices are generally made on a case-by-case basis. Decisions usually involve husbands, mothers-in-law, parents, relatives, or neighbours, or other authoritative people, like a village chief, a red chief, who act on behalf of the patient, especially in more serious and threatening situations. In the case of sick children, the child’s mother mainly consults with her husband or the mother-in-law. The decision is taken by the husband and corresponds with the availability of healthcare and financial possibilities of a family, as well as with what is deemed appropriate treatment, medication and care. Like any other kind of behaviour, health-seeking is founded on social values. Social values silently define which particular behaviour is expected from a woman or a man, particularly when related to health. Social prestige or conversely, shame, social discredit and stigma are related to whether actions conform to expectations or violate these. The question is how and to what extent social values hinder or facilitate health-seeking behaviour. We have previously discussed rules and regulations during pregnancy, and the health consequences when these are not respected. Fear of being labelled a bad mother, or shame because one’s child looks dirty, ill or too thin, etc. can all act as an obstacle to seeking healthcare. By contrast, owning a mosquito net can be a sign of wealth or responsibility, and caring for the family is a source of prestige for men (the responsible father).

### 4.12.4 Medical pluralism

Medical pluralism refers to the different types of healthcare provision that coexist in a territory and their relation to reach other. Whereas people constantly said that malaria is best treated in a formal healthcare
facility, convulsions are still treated by the traditional healer, often in combination with biomedical treatment. The treatment options people refer to are self-treatment at household or community level, traditional, complementary and alternative medicine with healers and TBAs, and biomedicine in a professional healthcare facility. Kleinman developed the concept of healthcare systems and differentiated the popular, folk and professional sectors. The “popular sector” refers to self-treatment, the “folk sector” to treatment with healers and TBAs, and the “professional sector” to the PHCUs and PHCCs, or any other formal healthcare facility further away, like Kapoeta, Ethiopia, or in rarer cases, Juba.

4.12.5 Perceived quality of services available and provided

The perceived quality and effectiveness of healthcare services are key factors for people when deciding where to seek help. From the interview data, we could see that people return to the healthcare structure where they were successfully treated and from where they received the expected medication (quantity and type of medication). The following quote exemplifies how people sometimes try to get medication to take to far-off places like the cattle camps, since access from there may be more difficult.

“The patients will direct you the doctor [midwife], instead of us directing them. Sometimes people want to bring drugs for the other people in the cattle camp. The same person comes three times in a week with different problems, to get different drugs so maybe this person is doing some business, or for people that are far.” I32, GI MoH staff, Boma

In the assessed area, access constraints outweighed the perceived effectiveness of treatment, and people were forced to fall back on services they do not deem the most effective. Perceived quality is also related to expectations to receive a certain number of drugs, specific medication they had used before, or receiving an injection rather than pills. The following quote illustrates how people define ‘good treatment’:

“You will be injected, and you will receive tablets to take home and also you are admitted if you have positive malaria.” I36, woman, Kassangor

Drug shortages in the PHCUs and PHCC meant that people were referred to facilities further away, like Kapoeta or Ethiopia, or to places they could not afford, like the private clinic in Boma. Therefore, people felt that the PHCUs and PHCCs were unreliable. Issues cited during interviews included lack of medication, materials and services.

4.12.6 Prior experiences of different healthcare sectors

Decisions about where to seek healthcare are influenced by prior experiences with treatments received from providers, including the experience of others. This contributes to satisfaction or dissatisfaction and generates expectations, as well as influencing perceptions of the quality of care available. Prior experiences provide a frame of reference for the comparison of different preventative tools and/or healthcare providers, as seen when people were comparing MERLIN with CARE. In addition, prior experience of a disease (like syphilis or malaria) helps build up cognitive schemas on disease manifestations, which are essential for symptom recognition and healthcare choices. Nearly all community members reported poor treatment and unsatisfactory medication provision by CARE and compared these services to MERLIN. The experiences with CARE caused people to lose trust and faith. Such experiences deterred not only the people who were directly affected, but also others within the community. Consequently, respondents spoke of avoiding the PHCC and using alternatives instead.
4.12.7 Coping strategies

In the course of the assessment, understanding the very difficult living conditions, and associated with these, the complicated access to healthcare, we tried to evaluate how people coped with their challenging circumstances. Historically, this area has been prone to natural disasters, conflicts, cattle raiding and diseases for a long time. In this sense, family networks are vital for mutual support. Verswijver, citing Knighton, reminds of three enemies of a cattle herder’s quality of life: drought, disease and raiders (Verswijver, 2015), which all affect people directly or indirectly, since they concern their cows (Knighton, 2005).

In the areas we have visited, we identified four different ways of coping. A difference was observed between the Murle and the Jiye regarding alcohol abuse.

- Love for the country
- Faith in God
- Hope derived from MSF or other NGOs
- Alcohol used as food replacement

Love for the country/homeland

Some respondents expressed their love and affection for and loyalty to their country and homeland. They do not want to leave, and hope for a better future.

“Since it is our land and with all these difficulties there is nothing we can do. We stay because it is our land. We live from the cows, but they are raided now, we just stay.” I4, GI women, Maruwo

“We have nothing to do we are just here, it is our place, we just stay.” I23, GI young women Boma

Fatalism and faith in God

Another way of coping expressed by some respondents was that God would help and that people believed in God to help them and that the ultimate fate, whether one survives or not, lies in God’s hands.

“Nothing will help unless you will die.” I30, GI men Naoyapuru

“Here we only survive because God has granted us, and it is God that is taking care of us.” I5, GI women Maruwo

Hope in NGO support – MSF

The hope that is placed in NGOs and specifically in MSF to help and support the population was omnipresent during our assessment. In all the areas we visited we understood that people depended on the support of NGOs to help overcome natural catastrophes like droughts, floods and human-made conflicts like cattle raiding, and to treat the diseases of both human beings and animals.

“We heard about MSF in Pibor, some of these chiefs you see we pray that MSF comes to rescue us here. MSF should come in and rescue us, or any other partner. We need assistance. You should stay until May, June July it is getting worse, up to December it is dangerous.” I3, GI leaders, Maruwo

“We will just produce many children, even if others are fasting away others will remain, God will assist us. A malnourished child is not good, but you, white people, you are the people that can help them [the children] to bring them food to feed them and bring medicine.” I40, leaders Kassangor
Alcohol instead of food

In chapter 4.7. we discussed nutrition and malnutrition, and mentioned that due to the lack of food, people resorted to alcohol. Replacing food with alcohol is a coping strategy intended to deal with hunger. One young Jiye man said that “local brew is like food”.

“When you drink the local brew you will be satisfied, you do not feel hungry, if you lack food we drink more.” I9, elderly man, Kassangor

“The problem is the hunger, when there were cattle before, we were after cattle and did not drink but now there are no cattle and we drink alcohol. Now we have nowhere to go, all are in the village; even young men and women drink alcohol. Before it was not much.” I40, leaders, Kassangor

The problem of alcohol consumption can only be tackled when enough food is available, and enough food means both enough cattle and a sufficient harvest of sorghum and maize.
5 Recommendations

The following recommendations are the result of the analysis of the field assessment, exchanges with MSF South Sudan and international staff working in the GPAA and Juba, and of discussions and debriefings with technical referents from the cell and medical department of OCB. Informal discussions with colleagues at the project level and discussions with other anthropologists who have previously worked with the Murle in South Sudan have also informed the analysis.

These recommendations advocate a community engagement approach and are presented to inform future project activities in the GPAA, which in the first phase would target Maruwo and Boma with its surroundings, and in the second phase would extend to Labarab and Kassangor.

For Boma, we should bear in mind that “what people experienced with MERLIN may be what they hope for in their encounter with MSF.”

In the CoPro, the following key points for the medical response and approaches are summarised as follows:

- Provide access to healthcare for the most remote villages/populations
- Increase the use and acceptance of healthcare facilities by adopting a collaborative approach, including supporting health and nutrition actors in the PHCC and PHCUs by focusing on the most vulnerable group (children under the age of five and pregnant/lactating women)
- Community approach and involvement: iCCM with CHWs, TBAs and other traditional healers (the aim is to have some of them as allies). The iCCM approach needs to be complementary to the current Boma healthcare initiative, which is supported by CARE International/Live well
- Consider HP activities from the beginning for each medical activity proposed
- Build capacity through relevant and ongoing supervision/training for all activities proposed (Boma PHCC included), with the MSF academy healthcare as our main asset from the outset
- Adapt the approach to seasons and movements of the population/cattle keepers (Maruwo, Labarab, Kassangor). This flexibility of approach is mainly necessitated by the challenges that arise from reduced healthcare access due to distances and logistical constraints during the rainy season
- Implement a decentralised outreach project with increasing geographical coverage throughout its development

**Dry season:** decentralised approach with mobile clinics (remote villages and cattle camps) and iCCM

**Rainy season:** outreach approach, no mobile clinics but iCCM

5.1 Community engagement approach

Apart from medical activities, the project should promote a strong community engagement approach in order to create active participation from the side of the community, so as to encourage not only sustainability, but also stability. Therefore, a strong link with key actors, and even more so with important medical actors from the communities is paramount.

For such community engagement to be successful, these key (medical) actors should be identified and form the starting point when designing an engagement strategy that is based on mutual respect and trust. The key
actors should be identified by characteristics like gatekeeper, decision-maker, influencer, practitioner etc., and as village chiefs, red chiefs, leaders, TBAs and traditional healers.

For this approach, the power dynamics within a family or community should be thought of in terms of decision-making within the families and communities. Additionally, it is important to look beyond the power dynamics and to think of social and structural factors. For example, in Kassangor we were made aware that the decision to walk to Boma did not only depend on financial means and the encouragement of the husband or mother-in-law, but also on the availability of people needed to form the travelling group.

The HP manager should be a key team member, who defines the health promotion strategy that determines how the community engagement is to be conducted, and which tools and activities are to be used. Such an approach may create a need for more information, which can be obtained through qualitative data collection to better understand the populations’ healthcare coping strategies, and barriers or enablers in accessing healthcare.

A few important points to consider for successful community engagement are:

**Give community members a voice and the space needed**

The most important element of any community is its members; it is not about MSF practitioners, but about them. People share what matters to them and this is something we should encourage. The more people feel that they are being listened to, heard and valued, the more likely they are to remain committed and engaged.

**Community engagement starts with understanding and adding value**

Let us refrain from an ethnocentric mindset. If we come with an open attitude and create collaborations together with the communities in question we will get great responses and commitment from the people we work with.

**Monitoring and supervision**

At the community engagement level, we can ensure an open dialogue with the community and maintain a solid link with key actors if we engage in constant information sharing and feedback on services, detection and correction of rumours and misunderstandings as well as in collaboration with other stakeholders, which is especially relevant for the iCCM approach.

Before going into the different perspectives of community engagement, it is useful to make an observation about the age-set systems in both societies, Murle and Jiye. A lot has been written and talked about the age-set systems, and some publications have oversimplified the age-set system, or confused it with the generation-set system. Going into detail would be beyond the scope this report, but two papers by Mueller-Dempf, who has conducted studies among the Ateker groups, can be consulted (Mueller-Dempf, 2009, 2017). Briefly, while the generation-set is vertically structured and inherited from the father, the age-set is horizontal within a given age group.

I think it is important to take into consideration the importance of age-set affiliation. Especially in Kassangor and in conversations with key informants in Boma, it was communicated that members of the same age-set group are permanently ‘bonded’. They move together, sit together, discuss and solve social problems within

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37 Refer to chapter 4.1. for their role in the society.

38 A first reference is this report, but while analysing the data it was noted that there is a need for more in-depth information on various topics. For example, no interview was conducted with a Jiye TBA or Jiye healer.
the group; they support each other and are related for their entire lives. It was even said that a man was not allowed to mingle with other age-set members anymore once he has joined his own.

“I was harassed by my generation because I socialised with different people, so they called me to their gathering and they asked me why I do that, I explained but they warned me and I stopped. Now I meet only the Bothonya. They could beat me and punish me and make me pay in kind, money or cow (it is not much only 10,000 SSP), if you join another generation you pay.” 126, young man Boma

This feature is highlighted in the light of HP interventions. In Kassangor we saw elder men lying under a big tree where we had organised a mobile clinic. It was only the members of one age-set who sat under this tree, since each age-set has its own tree where they sit in the shade and rest. Therefore, it would be good to consider having age-set groups linked together for certain activities. There may be a spokesman for an age-set group; in this case, this person could be a community intermediary for community engagement strategies. As previously mentioned, women join the age-set of their husbands. In Maruwo we noticed that women/TBAs of the same age-set work together; in that case they were women of the Dorongwaa age-set.

5.1.1 Collaborating with TBAs

Collaboration with TBAs should start with an exchange of knowledge and skills, and then move on to training with a qualified midwife to transfer skills which TBAs do lack. This training should conclude with the provision of materials, like gloves, cotton, razor blades, soap etc. We have to consider that deliveries will still take place at home and therefore, TBAs need materials available at home. Collaboration with TBAs should start with mapping all available TBAs who are interested in cooperating.

How?

♦ Invite TBAs to the PHCU and let them do the job with a midwife. If we want to encourage ANC, childbirth and PNC at the PHCU, it is important to have a diverse and inclusive patient and people-centred approach. TBAs should be considered partners and not ‘persons who are used only to refer pregnant woman’; they should participate in the actual childbirths at the PHCU.
♦ Let women choose whether they want to deliver in a squatting position or on a bed or chair
♦ Let them choose if they prefer to deliver in a tukul specially prepared for delivery in a squatting position, or on a bed or chair in a room within the PHCU.
♦ Let them decide if they want the delivery to be attended by the midwife or the TBAs, or by both

Be prepared that a delivery is attended not by one TBA, but by at least two or three! So, we have to question whether we ready for that.

Why?

♦ Because the TBA will still be there and will do the job after MSF leaves
♦ To be more sustainable for a handover to another NGO or MoH
♦ During conflict and natural disaster, they are the only available resource
♦ For sustainability and knowledge transfer

39 It should be validated by the HP team if the age-set affiliations of CHWs need to be considered.
40 See annex 7.3.
What is the aim?

The aim is to promote ANC, PNC and childbirth at the PHCU. TBAs are highly respected and trusted, and women and their families choose the best one if they can. Therefore, their cooperation and support in promoting maternal health services at healthcare facilities can positively influence health outcomes.

5.1.2 Integrate traditional healers

The collaboration and integration of traditional healers may only be relevant in certain areas, as we were told that in Maruwo and Boma, people did not trust traditional treatments anymore. However, traditional treatment rituals are still ongoing on a regular basis in Labarab and Kassangor and a way has to be found to collaborate with them. For example, one traditional healer in Labarab is also a TBA and additionally, she is the women’s representative. A way of collaboration with traditional healers could be to include them as CHWs.

Traditional healers hold an important role as advisors on patients’ treatment paths. We heard that in some areas, people check with the healer where they should seek treatment, and whether witchcraft is involved in the disease. Despite our study findings, which suggest that community members generally prefer biomedical healthcare (in all areas), people’s trust in alternative healthcare providers, such as TBAs and traditional practitioners also remains high (especially in Labarab and Kassangor).

Through outreach and HP activities, MSF could facilitate a mapping of those healers who are still active in treatment and ritual performances, and who would be interested in collaborating with us. An initial mapping of healers would determine which kinds of alternative healthcare providers are active, and describe what they offer. It would also help to further understand which harmful practices are still performed and how these could be tackled together with the healers involved.

By organising a dialogue workshop, MSF could foster a discussion that compares traditional perceptions and ideas around witchcraft with biomedical perspectives related to diseases, pregnancy, labour and childbirth. Such a workshop could help healthcare providers gain a more concrete understanding of previous health-seeking behaviours. It could also give traditional healers an opportunity to explain to healthcare providers why people consult them, and why and how they treat them. Raising awareness of the importance of early detection of complications when children are sick or during childbirth, and earlier referrals to the PHCU, could be triggered by such collaboration. This might further generate mutual respect, appreciation, and trust among PHCU facilities, traditional healers, MSF, and other actors, leading to improved health for the population.

5.1.3 Implement integrated community case management (iCCM)

Communities (for example in Boma) are not satisfied with the quality of services provided in the formal healthcare system (CARE), and due to the lack of access to healthcare, they are forced to rely on self-treatment and alternative healthcare providers.

The first link between the formal healthcare facility and communities is usually established by CHWs. CHWs are the eyes and ears that sense what happens in the communities in which they live. Their role is crucial in linking communities with PHCUs, and therefore the iCCM programme should be an integral part of a

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41 Her name is Walaker. We conducted an interview with her without knowing that she is also a TBA and traditional healer. When I tried to meet her for another interview to talk with her about her role as a traditional healer, she was too drunk to talk to.
community engagement approach delivered by CHWs.\footnote{42 If they are to be named as such.} CHWs should be appointed in every village and also in the cattle camps, and they should be trained, equipped, supported and monitored by MSF. We need to find the best persons to fulfil this role, whether they should be male or female, and who is likely to be amenable to being approached for iCCM service etc. Should we call them CHW, or maybe their role can be linked with the iCCM model, so that they are called iCCM providers, to leave behind the old model of CHWs. We could think of a new, creative designation for the role if deemed a good idea by the HP team and project team on the ground, including local actors. They could be asked; maybe they have a fantastic idea! One very important aspect is to find out if we need to consider the age-set organisation of men in order to find out which person would be the best fit for which age-set group. Do we also need to consider the age-set affiliation of the CHWs? The HP team should figure out if this is relevant to consider.

5.1.4 Quality of care provided at PHCC and PHCU level

This feature has been discussed at length throughout the report and needs to be tackled mainly by the medical team. Therefore, in this report we refer to the CoPro proposal. From an anthropological point of view, we would like to emphasise the importance of a welcoming attitude towards patients and caretakers and a patient-centred approach. Such an approach means both kind and timely treatment from healthcare providers, with an appropriate explanation of any diagnosis and treatment (something that is always provided by traditional healers). The treatment should make sense to the patients and caretakers. The perception of quality of care is strongly linked to the type and amount of drugs and medication prescribed. Quality of care, i.e., quality of treatment are perceived as synonymous with the ‘quality’ of medication (type and amount).

5.1.5 Motivate and encourage health-seeking behaviours at community level

It is common for people, and not only in South Sudan, to use multiple providers, either consecutively or simultaneously, to maximise chances of recovery. To influence health-seeking behaviours and to minimise any unintended consequences of harmful treatment practices, we analysed the factors that influence the treatment path people take up. Health-seeking behaviour is based on users’ trust in the healthcare provider and services they are able to offer; to minimise inappropriate ‘healthcare shopping’ at community level and to maximise committed biomedical healthcare provision, the greatest challenges lie in correcting the structural deficiencies which people are confronted with – in short, lack of healthcare facilities and healthcare provision.
6 Conclusion

This assessment was conducted to map the population’s needs respecting and access to healthcare, factors influencing health-seeking behaviours, and the coping strategies developed to compensate for the absence of any formal healthcare provision. The questions that have been tackled address details of the main health problems, how people experience and navigate their own health-seeking behaviour and explore the scarce and unsatisfactory available healthcare choices, which alternative healthcare options are available, and what the practices of traditional, complementary and alternative healthcare providers are, when, how and for what ill-health conditions they are consulted, and which factors influence where people seek care. In Boma county, access to healthcare is poor and in some remote and isolated places, nonexistent for two reasons: 1) lack of healthcare facilities and 2) challenging geographical accessibility.

People’s treatment path first involves herbal self-treatment at household level, before navigating other available options, which are often nothing more than a small PHCU, a traditional healer or somewhere ‘outside’ their place of residence, which includes travelling (walking) to Kapoeta or Ethiopia.

As it stands, the PHCC in Boma is not an option considered as part of the health-seeking path because of a lack of equipment, materials and services, the interrupted drugs supply, insufficient human resources and a lack of trust towards the facility as a whole. People may engage in that journey as a last resort, and only when they do not have money to go elsewhere, such as Ethiopia, Kapoeta, or to the private clinic in Boma market.

The assessed locations have great potential and existing resources, such as key actors in communities who could be integrated into an iCCM approach.

Women are at the centre of everything; they bring wealth to the family due to the gifting of cows as dowry and give birth to children for the continuity of the lineage. Without women, there would be no children and without healthy women, there are no healthy children. Therefore, special focus should be placed on women of child-bearing age and on children, with the rest of the population integrated additionally.

The local people I have talked with have shown a high level of resilience, but they cannot solve the inadequate healthcare situation on their own. Dependence on the support of NGOs seems to be a precondition to improve access to healthcare. MSF is needed to assist both people in the GPAA and the formal health sector in providing accessible healthcare options to cope with their ailments. In that sense, ‘food’ is needed for survival because “medication is like food”.
7 Annex

7.1 References


Felix da Costa, D. (2013). ‘We are one, but we are different’: Murle identity and local peacebuilding in Jonglei State, South Sudan. NOREF Policy Brief. Oslo.


### 7.2 Anthropologist’s work plan

#### WEEK 1+2+3

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<tr>
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<td>16 January</td>
<td>Departure from Vienna to Juba</td>
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<tr>
<td>Sunday</td>
<td>17 January</td>
<td>Arrival Juba</td>
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<tr>
<td>Monday</td>
<td>18 January</td>
<td>Start quarantine 14 days</td>
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<td>02 February</td>
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<td>Boma meeting officials</td>
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<td>Maruwo: I:9 TBA, I:10 health staff</td>
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<td>Maruwo: I: 14 TBA</td>
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<td>12 February</td>
<td>Travel from Maruwo to Labarab</td>
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<td>Saturday</td>
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<td>Labarab: I:15 women</td>
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<td>Sunday</td>
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<td>Labarab: I:16 leaders, I:17 men/Youth, I:18 TBA</td>
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<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
<td>17 February</td>
<td>Travel to Boma</td>
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<tr>
<td>Thursday</td>
<td>18 February</td>
<td>Boma: I:21 leader</td>
</tr>
<tr>
<td>Friday</td>
<td>19 February</td>
<td>Boma: I:22 TBA, I:23 women, I:24 Youth</td>
</tr>
<tr>
<td>Saturday</td>
<td>20 February</td>
<td>Boma: I:25 health staff, I:26 man</td>
</tr>
</tbody>
</table>

#### WEEK 6

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>Monday</td>
<td>22 February</td>
<td>Naoyapuru: I:30 men, I:31 women</td>
</tr>
<tr>
<td>Tuesday</td>
<td>23 February</td>
<td>Boma: I:33 man, I:34 Man</td>
</tr>
<tr>
<td>Wednesday</td>
<td>24 February</td>
<td>Travel to Kassangor I:35 woman</td>
</tr>
<tr>
<td>Thursday</td>
<td>25 February</td>
<td>Kassangor: I:36 woman, I:37 women, I:38 men/youth</td>
</tr>
<tr>
<td>Friday</td>
<td>26 February</td>
<td>Kassangor: I:39 man, I:40 leaders</td>
</tr>
<tr>
<td>Saturday</td>
<td>27 February</td>
<td>Travel to Boma</td>
</tr>
<tr>
<td>Sunday</td>
<td>28 February</td>
<td>Writing up first findings</td>
</tr>
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#### WEEK 7

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>Monday</td>
<td>01 February</td>
<td>Writing up first findings, debriefing with assessment team</td>
</tr>
<tr>
<td>Tuesday</td>
<td>02 February</td>
<td>Departure from Boma to Juba</td>
</tr>
<tr>
<td>Wednesday</td>
<td>03 February</td>
<td>Writing up first findings</td>
</tr>
<tr>
<td>Thursday</td>
<td>04 February</td>
<td>Writing up first findings</td>
</tr>
<tr>
<td>Friday</td>
<td>05 February</td>
<td>Debriefing with HoM</td>
</tr>
<tr>
<td>Saturday</td>
<td>06 February</td>
<td>OFF</td>
</tr>
<tr>
<td>Sunday</td>
<td>07 February</td>
<td>Departure from Juba to Vienna</td>
</tr>
</tbody>
</table>
7.3 History of the Murle age-set system

A new age set was created in Likuangole named Guzule with the colours black and white, its members are born around 2000 up to date.
7.4 Calendar of seasons and key livelihood events

Da Costa writes in her dissertation: According to a USAID Survey published in 2001 (Deng 2001, 31), before the second civil war the average household in Murle Boma used to cultivate over three acres of land with maize and inter-cropped with small quantities of sorghum for seed, in the first season that starts in March/April. The same area was then cultivated in the second season (August/September) with sorghum inter-cropped with small quantities of maize (for seeds in the first season). In addition to sorghum and maize, which remain the two main crops of subsistence, beans, cassava, potatoes and vegetables are also grown. Fruits, particularly banana and mango, but also guava, paw-paw, sugar-cane and lemon, can also be found abundantly in Upper Boma (Felix da Costa, 2016).

See below a calendar of the seasons and key livelihood events taking place by group.
7.5  Question guide

In-depth interview guide: general population

1. Can you tell me a little bit about yourself?
   **Prompts:** age, place/village of origin or actual residence (language), marital status, family background, number of children, education, occupation, age-set

2. Can you tell me about the main health problems people face here in this area?
   **Prompts:** main health problems, reasons for these health problems, perception of these health problems, where and how they can be treated, other alternative options for treatment, local names for certain diseases or ill-health conditions

3. Can you tell me about pregnancy and childbirth in general in your community?
   **Prompts:** state of pregnancy, rules and regulations during pregnancy, special behaviour and protection expected, problems during pregnancy, causes of these problems, choice and place of childbirth, decision maker where to give childbirth, factors influencing this decision,

4. Can you tell me about the different healthcare options available to you in your area?
   **Prompts:** clinic, hospital, traditional healer, mobile health such as vaccination campaigns, home treatment, self-medication, payment at the different healthcare options

5. Can you tell me how you decide which healthcare option you choose?
   **Prompts:** decision, factors influencing decisions, which option for which disease (malnutrition, sexual violence, spontaneous abortions)

6. Which of these health options do you usually prefer and why?
   **Prompts:** Any negative views or preferences on any kind of healthcare, or vaccinations, Different healthcare options for different diseases

7. Can you tell me what you have heard about traditional healing in your community? How do your neighbours/village members view community healing?
   **Prompts:** if person is not able to discuss their own experiences, ask them to discuss if their neighbours/local community members consult healers. Probe for what kind of healers and services are offered. Trust? Scared?

8. Have you ever visited a traditional healer? If yes, can you describe this experience to me? Can you describe how long you stayed with the healer and what the experience was like? Why did you go, what kind of care was provided, who accompanied you, treatment received, how many times you visited?
   **Prompts:** experience with traditional healers, community perception, practices, adverse outcomes

9. Can you explain to me why you decided to visit the traditional healer?
   **Prompts:** how to choose a specific healer, factors contributing to health-seeking behaviour of traditional healers

10. Can you describe what your relationship is like with the traditional healer?
    **Prompts:** trust, knowledge of the healer, recommendation, cost, proximity, type of illness visited for

11. Can you tell me about the kind of treatment you received from the healer? How did you feel about it?
    **Prompts:** understanding of disease and treatment, satisfaction, consulted someone else after?

12. Can you tell me about how long after the first symptoms started, you decided to access care? Were there any reasons you waited for access care?
    **Prompts:** too far, cost, prefer traditional healer, others in my family told me not to, child was too ill to travel
In-depth interview guide: Healthcare professionals (INGO and MoHS)

1. Can you tell me a little bit about yourself? About your role and specialty?
   **Prompts:** age, place/village of origin or actual residence (language), marital status, family background,
   number of children, education, occupation, age-set

2. Can you tell me about the main health problems people and especially women and children face here in
   this area?
   **Prompts:** main health problems of women, reasons for these health problems, perception of these
   health problems, where and how they can be treated, other alternative options for treatment, local
   names for certain diseases or ill-health conditions

3. Can you tell me about pregnancy and childbirth in general in your community?
   **Prompts:** state of pregnancy, rites and customs/rules and regulations during pregnancy, special
   behaviour and protection expected, problems during pregnancy, causes of these problems, choice and
   place of childbirth, hospital or TBA, decision maker where to give childbirth, factors influencing this
   decision

4. Can you tell me about the different healthcare options available?
   **Prompts:** clinic, hospital, traditional healer, mobile health such as vaccination campaigns, faith healers
   etc., self-medication/treatment at home, homemade drugs, used before during or after going to the
   clinic etc., payment

5. Can you tell me what you have heard about traditional healing?
   **Prompts:** knowledge and perception of traditional healing

6. Have you ever visited a traditional healer? If yes, can you describe this experience to me? Can you
   describe how long you stayed with the healer and what the experience was like? Why did you go, what
   kind of care was provided, who accompanied you, treatment received, how many times you visited?
   **Prompts:** experience with traditional healers, community perception, practices, adverse outcomes

7. Which illnesses do patients come to you with? Which do they treat through traditional healers?
   **Prompts:** ‘hospital disease’, causes of disease, health-seeking behaviour, influencing factors on HSB

8. What is your experience with patients’ expectations once at the health centre/hospital?
   **Prompts:** waiting times, barriers, receiving treatment (injections, drugs, etc.)

9. What factors do you believe influence health-seeking behaviour?
   **Prompts:** distance, family’s financial situation, knowing a healer, relation to the healer, previous
   experience with a healer

10. How do people perceive allopathic/modern medicine?
    **Prompts:** perceptions of medicine and illness, health-seeking behaviour, medication, perception of
    healthcare institution

11. What is your perception on traditional healing?
    **Prompts:** kind of treatment provide, success or failure of traditional healing, previous experience of
    traditional treatment, recommendations of others, payment

12. Can you tell me about patients that see traditional healers before coming to a health centre? Have you
    seen cases of traditional healing? How do you deal with patients with previous traditional treatment?
    **Prompts:** health-seeking behaviour, perceptions on traditional healing, treatment of patients, receiving
    patients (welcoming)
In-depth interview guide: Traditional healers/TBAs

1. Can you tell me a little bit about yourself?
   Prompts: age, place/village of origin or actual residence (language), marital status, family background, number of children, education, occupation, which kind of healer, self-description, age-set

2. Can you tell me more about the role you play in the community? What does your work involve? Why do people come to you? When do people come to you?
   Prompts: Trust, how he/she calls him-/herself, specialty in healing, becoming a healer

3. Could you tell me how you learned your craft? How do you keep your knowledge up to date?
   Prompts: becoming a healer, inheritance, traditional healing knowledge, from whom learned, with whom exchanging

4. What are some of the most common things people come to see you for?
   Prompts: common illness, prevention, rituals, bath, other healers sent the patient, relationships to patients, causes of disease

5. Can you tell me about some common remedies you offer to patients when they come to see you?
   Prompts: traditional healing practices, rituals, prayers, plants, massages, bath, ...

6. What kind of treatments do you prescribe? Can you provide an example?
   Prompts: traditional healing practices, adverse outcomes, multiple treatments for one ailment, herbal or other medication, overdose, medication leading to intoxication (seen so by health staff) or antibiotic resistance, payment

7. How would you describe the kind of relationship you have with your patients?
   Prompts: Trust, any issues, status in community, which kind of patients, who is not coming to see them (healer not trusted or some people are not welcome), access and stigma (healer’s reputation)

8. What other forms of healthcare are there in your community?
   Prompts: Vaccination Campaigns, Clinic, Hospital, Home, faith healers, other healers with a specialisation

9. What do you think about other forms of healthcare? How do you feel about referring patients to other forms of healthcare?
   Prompts: influence of traditional healers on health-seeking behaviour, possibility of incorporating traditional healers better in health landscape, patients coming back after clinic or hospital stay, MSF facility, patients’ follow up, to discuss treatment from other health facilities

10. How do you see the difference between you and other forms of healthcare?
    Prompts: other healers, hospital, difference to a nurse or a doctor, specialisation, holistic approach, body and mind, physical and mental, supernatural and natural

11. Where do you or your family members go for treatment when you fall sick?
    Prompts: the healer him or herself and their family members, to whom with which disease, how do they decide, or what influences the decision
1. Please tell me about the main health problems people and especially women and children face here in this area?
   **Prompts:** main health problems, reasons for these health problems, perception of these health problems, where and how they can be treated, other alternative options for treatment, local names for certain diseases or ill-health conditions

2. Please tell me about pregnancy and childbirth in general in your community?
   **Prompts:** state of pregnancy, rites and customs/rules and regulations during pregnancy, special behaviour and protection expected, problems during pregnancy, causes of these problems, choice and place of childbirth, hospital or TBA, decision maker where to give childbirth, factors influencing this decision

3. Can you tell me about the different healthcare options available to you in your village?
   **Prompts:** clinic, hospital, traditional healer, mobile health such as vaccination campaigns

4. Can you tell me how people decide where to go for treatment?
   **Prompts:** self-treatment/medication, decision, factors influencing decision, which option for which disease

5. Which of these health options do people usually prefer and why?
   **Prompts:** Any negative views on any kind of healthcare, or vaccinations, different healthcare options for different diseases

6. Can you tell me what you have heard about traditional healing in your community?
   **Prompts:** if person is not able to discuss their experiences, ask them to discuss if their neighbours/local community members consult healers. Probe for what kind of healers and services are offered. Trust? Scared?

7. Why do people come to see traditional healers?
   **Prompts:** how is the healer chosen, kind of diseases treated, causes of disease, experience with traditional healers, community perception, practices, adverse outcomes

8. How can the current healthcare system be improved?
   **Prompts:** health-seeking behaviour, trust
The Vienna Evaluation Unit

The Vienna Evaluation Unit was established in 2005 to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises and anthropological studies and organises training workshops for evaluators. More information as well as electronic versions of evaluation and anthropology reports are available at:

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