

## MILITARISM, GENDER AND REPRODUCTIVE SUFFERING: THE CASE OF ABORTION IN WESTERN DINKA

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This article addresses the issue of abortion and reproductive suffering among the Dinka in an emergency relief centre called Akon and in a number of adjacent villages in south-western Sudan (hereafter, Western Dinka). It does so in the context of culturally defined gender relations and the culture of militarisation of the young male population. It looks at reproductive strategies in the light of the larger framework of gender relations and changes in behaviour resulting from the conditioning of young males to violence which limits the options available to women of reproductive age as regards sexuality and reproductive decisions. I am concerned with raising not only the question *do* these women abide by the expectations of the husband's family to become unwillingly pregnant, and hence risk reproductive complications, maternal mortality, infertility or death from induced abortion, but also the questions *how* and *why* they might do so. What does abortion or pelvic inflammatory disease and infertility mean to them? How do they explain their choices and interpret their behaviour? Finally, what is the role of gender structures and militarism in forcing women to make such decisions, although with less awareness?

### PERSPECTIVES ON CONFLICT AND REPRODUCTIVE SUFFERING

This article draws on some findings of an eighteen-month research project conducted during the period 1993–95. The primary concern of the project was the documentation of women's responses to upheavals of the civil war, which included the destruction of the subsistence economy and the disruption of family networks which had previously served as systems of care. I looked at how these changes had resulted in the reconfiguration of normative behaviours which functioned in the past to oversee sexuality and reproduction. I elicited information on reproductive behaviours and reactions to reproductive health problems through in-depth interviews and group discussions with a randomly selected core sample of twenty displaced women and forty other women in the host communities (see sample description below). The interviews also provided information on marriage, household structure, economic status, sexuality and reproductive histories, including abortion, problem pregnancies, stillbirths, child births and care.<sup>1</sup> For each marriage I collected information on the family size desired by the wife and the husband or her in-laws, the reasons for abortion, who performed it and with what, and perceptions of the risks it entailed. History of STD (sexually transmitted disease) infections, currently active infections, their

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<sup>1</sup> The results of the wider project are presented in Jok (1998).

traditional diagnosis, the treatments known and their accessibility were also recorded. Having tested the questions on reproductive health problems with a few women who were willing to discuss such topics with a male researcher, I employed a female research assistant to ask each woman a series of open-ended questions, such as 'Why do so many women miscarry or become infertile here?' 'What does a woman need most in order to have as many children as the family wants and for her to remain healthy at the same time?' 'What could most improve the health of women of reproductive age here?' 'Who do you resort to for help when a reproductive health crisis occurs?' In addition to the collection of data on reproductive behaviour from women, I conducted interviews with either their husbands, when present, or with other men in the family.

Given the rather sensitive nature of the study, it was not restricted to the randomly selected sample. Many women outside the sample who met the criteria for the project and who were willing to be interviewed were included. They in turn recommended other women who were also willing to be interviewed. Although interviews with these women have provided invaluable qualitative information, they are not a part of the core sample above. Interviews were also conducted with both expatriate and local health relief workers, and observations were made in the only clinic run by relief agencies in the entire region.<sup>2</sup>

Despite the communication problems around sex, abortion and childbirth, especially between a male ethnographer and women, I was able to work efficiently because Western Dinka was my home, where I grew up.<sup>3</sup> In fact, some of the men in the opposition army whom I interviewed were my school mates.

Although south Sudan has been the focus of numerous emergency intervention programmes since 1986 to relieve the upheavals of the unresolved civil war (1983–present), the area is still characterised by staggering unmet basic needs. The most recent data generated through assessment projects under the auspices of UNICEF indicate that the entire population of women is illiterate and life expectancy is forty years.<sup>4</sup> The New Sudan Women's Voice for Peace announced in 1995 that, out of approximately 1.5 million women in their reproductive years, 50,000 die each year in south Sudan, largely as a result of infections emanating from

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<sup>2</sup> Participant observations were made around reproductive health issues such as childbirth (I attended a total of ten births) and STD treatments (I acted as interpreter for women who sought health care with expatriate care-givers). However, matters relating to abortion were observed only casually. I spent hours at the clinic, three or four times a week, hanging around watching how the women approached the staff, how they were attended and what treatment they were given.

<sup>3</sup> It was initially difficult for women to see why I should study a culture I supposedly know, and how a 'young' unmarried man could break the rules of respectful restraint to ask women, who are his mothers in the Dinka order of things, questions about sexuality, pregnancy and abortion. Upon insisting, I was written off as a foreigner, for whom it was acceptable to ask absurd questions owing to my ignorance of their culture.

<sup>4</sup> Reports by Karamera and Kapuri attest to the suffering of women. OLS, Southern sector. Nairobi, Kenya.

clandestine abortions, untreated STDs, difficult births and maternal malnutrition, all in addition to tropical and parasitic diseases.<sup>5</sup> Ironically, the Operation Lifeline Sudan (OLS), a United Nations-led consortium of relief agencies attempting to rescue war victims of south Sudan, while markedly supplementing dwindling local resources, has not had a correspondingly favourable effect on women's mortality, which has been rising steadily in displaced persons camps since the mid-1980s.<sup>6</sup>

Recent studies of maternal and child health under conditions of civil strife and social disruption in Africa found the highest rate of maternal mortality of all the refugee and internally displaced populations studied to be among the displaced south Sudanese women in northern Sudan (Burr, 1990: 25). The journal *Social Science and Medicine*<sup>7</sup> devoted an entire issue to data on the health of war-affected populations. The data on women's health present a profile of the women most likely to be at reproductive risk. The women at risk have suffered an STD, unconventionally increased fertility, childbirth-related complications or, ironically, infertility. Those are the women who are likely to die. They are illiterate, rural residents displaced to an urban area or to a relief centre; they are unskilled and therefore marginally employed. They are also likely to have become the heads of their households, either because the husbands are at the war front or because they have been killed or displaced to different locations.

Some of the frequent experiences of women in many war-torn regions of the world are loss of control and power of negotiation over sexuality and reproductive decision-making (Olujic, 1998: 31; Theweleit, 1993: 283; Brownmiller, 1993: 37). These include marital rape, forced prostitution, and sexual and emotional harassment. Equally important is the reduction in state services, leading to increased stress and work load for women. This also includes denial of health services and increased disruption of social institutions that control such behaviour as adolescent sexuality (O'Connell, 1993: ii; el Bushra and Piza-Lopez, 1994: 180). The list goes on. But what threatens women's reproductive well-being most, especially in 'pronatalist'<sup>8</sup> societies in transition such as south Sudan, is that society responds to increased rates of infant mortality by urging women to maximise their reproductive activity in order to replace the lost ones (Hutchinson, 1996: 251; Scrimshaw, 1978: 383; Chowdhury *et al.*, 1976: 249; Taylor *et al.*, 1976: 263). Consequently, the increased rate of infant death associated with the upheavals of war represents exposure to male breach of sexual taboos, frequent pregnancies ending in induced abortions or high birth rates and therefore, gross reproductive waste. This affects the physical and psychological health of women who conform to culturally defined norms

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<sup>5</sup> Sudanese Women's Voice for Peace is based in Nairobi and works in 'liberated areas' of the 'New Sudan'. In letters addressed to aid organisations and foreign governments the organisation has reckoned that women suffer most during the crises of war.

<sup>6</sup> I have discussed elsewhere the reasons why women slip through the net in relief efforts (see Jok (1996: 206, 1998)).

<sup>7</sup> See *Social Science and Medicine* 28 (7), 1993.

<sup>8</sup> Societies that place serious emphasis on high rates of childbirth.

of behaviour (sexuality, marriage and family) to satisfy the family expectations of childbearing.

The bulk of the literature on conflict and women's health has been written from the perspective of sexual violence (el Bushra and Piza-Lopez, 1993: 15, 1994: 180) and policy-oriented health services (O'Connell, 1993: v; Cliff, 1991: 15). Both perspectives tend to interpret the high rates of reproductive risk and disease characteristic of women and girls in emergency zones of the developing world as the almost inevitable consequence of the largely impersonal wide-scale destruction of communities and the weakening of household economic functions or support systems. These are observed to lead to heavier work loads and subsequent malnutrition. Reproductive risk is also viewed as a consequence of rape and forced prostitution, with the ensuing spread of sexual health problems which lead to further reproductive risks and life risks due to lack of health care.

While both approaches address many important issues about women's health during conflict, they frequently obscure the role of reconfigured societal rules of behaviour in the social production of women's reproductive risk—in other words, the community-level gender relations in which women are subjugated and their decision-making power over sexuality and reproduction is reduced. Such perspectives have also largely neglected the micro-perspective: the extent to which psycho-cultural factors come into play as emergency zone women, producers and reproducers, may be cast in the role of family fertility strategists. This presents them with the dilemma of reconciling reproductive expectations to ensure the continuity of the family name, and gain acceptance as worthy community members, with concern about their own health and the lack of resources for the older children. I am referring here to the hypothesis about the risks entailed in Third World women's resorting to clandestine and unsafe abortion as one of the few responses available to the lack of control over sex, lack of contraceptives, and the prevalence of culturally defined fertility patterns (Lane *et al.*, 1998: 1089; Stephenson *et al.*, 1992: 1328). This hypothesis suggests that highly stressed women of reproductive age may themselves contribute, indirectly, to higher levels of reproductive risk as a way of satisfying both community expectations and their own reproductive desires. For the purposes of this article, 'reproductive risk', therefore, implies two things: first, sexual violence, both marital and non-marital coercive sex (Heise *et al.*, 1995: 28); second, the gradual ability of women to appease their families by agreeing to be sexually available but practising the secret reproductive options necessary to avoid another childbearing ordeal under already extremely adverse conditions of social disruption and lack of resources for the care of the elder children. According to this hypothesis, owing to loss of assets, lack of family support, and their destruction of medical facilities, reproductive decisions such as induced abortion may be based on cultural preferences concerning the number of children already born, their sex, and individual calculations of whether children are an asset or a liability.

The evidence, however, upon which the 'reproductive risk hypothesis' is based has been largely circumstantial but sensational (as in the analysis of the statistics of sexual violence against women of a rival faction) or else anecdotal, since thorough social science investigations of sexuality under

conditions of conflict do not exist. Worse, preliminary analyses of reproductive risk in emergency zones are tainted by conspicuous ethnocentrism, such as references to what has been known as 'African sexuality' geared to fertility (Bailey and Auinger, 1995: 195). In the African sexuality model, because of their higher status, African men are said to focus on exposing their women to pregnancy, widows are said to be encouraged to remarry soon, premarital sex is not particularly discouraged, and the levirate institution (ghost marriage and wife inheritance) is operative.<sup>9</sup> These 'observations' are held to be evidence of reproductive risk whether in time of war or in time of peace (Lesthaeghe and Eelens, 1989: 25). This despite the recognition that what counts as sexual behaviour, sexual violence or non-intercourse play is highly variable across cultures. The variability of these concepts cannot be overemphasised as far as the African region is concerned. Furthermore, without careful attention to the context of the militarisation of a large part of the male population, and the economic and political conditions under which war-zone women rationalise their reproductive behaviour, the reproductive risk hypothesis could be readily interpreted as yet another variant of the tendency among some social scientists to blame the victims for an unfortunate situation. It can be further criticised for its even more general tendency to blame the gamut of human problems on unfounded allegations of sexual irresponsibility.

In this study I adopted a rather broad social epidemiological approach to women's reproductive suffering in Western Dinka, using reproductive risk as a kind of allegory of dynamic social relations and tensions in Dinka social life: between women and men, wives and in-laws, soldiers and civilians, the older generation and the younger, town residents and rural people, those labelled 'decent' community members and the 'bad' ones.<sup>10</sup> I have been trying to build up a history of sexuality as it relates to reproductive risk. In this connection, reproductive suffering is representative of the perilous effects of the militarisation of young males, violence within communities<sup>11</sup> and asymmetrical gender relations on women's sexual and reproductive lives. I have also attempted to assess the effect of such factors on women's ability to reconcile the community's reproductive wishes and their own well-being.

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<sup>9</sup> The levirate is a practice among the Dinka and Nuer of arranging marriage on behalf of a deceased man. The woman is assigned to a relative who will father children in the name of the deceased. A reproductive widow of reproductive age is also required by her marital family to continue childbearing with a brother of the deceased or another suitable relative. The children resulting from this arrangement are legally the children of the deceased, not of the 'pro-husband' who sired them. In social science the practice has also been termed ghost marriage, a misnomer. The issue has been the subject of spectacular misunderstanding.

<sup>10</sup> With reference to Dinka sexuality, 'bad' and 'good' are categories of immorality and moral integrity respectively.

<sup>11</sup> Sexual violence in war zones is usually thought to be inflicted by one army upon the people of the rival army. This certainly obscures the within-community violence that results from years of conditioning young people to the use of force. Changes in behavioural norms and gender relations and the disruption of the traditional system that functioned as watchdog are primarily implicated in this surge of violence.

## THE CONTEXT OF STUDY

*The community*

The area of study is inhabited by the Awan section of the Reik Dinka. It is an area of numerous small villages widely scattered, which used to be inhabited by approximately 50,000 people. Now it seasonally hosts about 20,000 more because of displacement to the relief camp set up in Akon during a major famine in 1989. Fifteen years of civil conflict and the well-armed Baggara Arab raids<sup>12</sup> throughout Western Dinka have caused massive displacement, loss of life and, loss of assets, causing severe food deficits in Western Dinka (Keen, 1994: 151; Majak, 1995: 7). One of the many consequences is the destruction of social services and social networks. Many young men have joined the Sudan People's Liberation Army (SPLA), and many more went north in the hope of finding employment. The relief centres have become home bases for many displaced women and children who have lost the supportive labour force of the men. Many of the men who were soldiers in the SPLA are busy with their military duties most of the time. There is no salaried employment for men apart from a few food-for-work jobs with relief organisations. The children are encouraged to hover around food distribution centres, the nutrition rehabilitation centre or the airstrip, where relief items are delivered by plane. Girls struggle with domestic chores while the mothers are out trying to secure some food.

Since 1989 many of the displaced squatters of Akon have become semi-permanent residents, although continuing to hope that they will return home at some point, and the makeshift grass huts are being replaced by small mud-wall homes. Security permitting, they receive the sporadic relief supplies delivered by OLS. Some of the displaced may attempt to produce their own food, depending on the kind of labour force a woman has. The women may also engage in petty income-generating activities such as the sale of grass and timber for building huts, the brewing of local alcoholic beverages, or working as domestic help in the households of the host community. However, lack of sanitation, poor water supplies and many communicable diseases remain life-threatening to all the inhabitants of Akon, especially to children, who become exposed to parasitic and other infectious diseases virtually every day, and to women, whose activities as the care givers and food producers expose them to heavy energy expenditure and maternal malnutrition. There are no latrines, and human waste is disposed of next to the homes, easily washed by rain into the river that runs through the villages. The lack of a clean drinking water supply is thought to be a major health problem in Akon, since there is only one borehole for the entire population of many villages. Long queues, high tension and short tempers as women compete for their turn, and the distance of the borehole from some villages,

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<sup>12</sup> The government of Sudan has often armed groups of the cattle-herding Arab tribes bordering the Dinka to carry out attacks on the Dinka and Nuer as a form of counter-insurgency warfare against the SPLA, in order to uproot the SPLA's alleged support base. These bands of raiders have severely destabilised the Dinka over the years.

have caused many households to resort to the river or shallow uncovered wells for their drinking water.

As far as health care is concerned, both the displaced and the host women of Akon have extremely limited access to relief health services. Where services are available they are wholly inadequate and limited in scope. The primary means of health care for the population of the region is obtained through local markets, where drugs smuggled out of government-held towns are sold. Traditional healers exist and practise actively everywhere, although the efficacy of their treatment has been questioned and their demands for compensation are deemed too high. Spiritual healing and herbal home remedies are commonly found as well, although not one has been found to be in use for treating STDs and other infections.

Despite some changes in Dinka marriage patterns, especially among the displaced, the core of the system in the host community remains the same. Residence is mainly patrilocal, with women marrying out of their natal clan and residing virilocally in villages composed mostly of kin. The ideal marriage is achieved through payment of cattle as bridewealth. Dinka is a polygynous society, with 45–60 per cent of men having more than one wife at some point in their lives. (Two wives was the average.)<sup>13</sup> When a man dies a bachelor, or is absent from home for a long period and there is no news of him, his family marries a wife for him. This woman is offered to a relative, preferably a younger brother, but first cousins and nephews<sup>14</sup> are also eligible. The same goes for a man who dies leaving behind a woman in her reproductive years. It also applies to a patriarch with many wives who doubts his fertility. He offers his junior wives to his sons by the senior wives. This is an intricate practice of disguised polyandry, so to speak.<sup>15</sup> The children resulting from the arrangement belong to the deceased, the absent, or the old man. The ratio of males to females, which would normally be asymmetrical, owing to polygyny, is balanced by the early marriage of girls. Girls reach the menarche normally between 13 and 15 years of age, and they are eligible for marriage shortly thereafter. A girl who remains unmarried beyond the third anniversary of the menarche is thought to have delayed. The desire for a large family is the norm in Dinka, and the woman is expected to become pregnant shortly after marriage—preferably within a few months to a year. Delayed pregnancy is grounds for suspicion of barrenness, which has unfortunate social consequences. It is usually justification for divorce, neglect or for the man to take another wife. There is no knowledge of modern contraceptives or their sources, nor is interest expressed in them by the knowledgeable few. Only two women who had received primary education and had lived in towns before the war knew about contraception;

<sup>13</sup> See note 6 above. Jok (1998) contains brief statistics of marital status.

<sup>14</sup> Any sister's son but only the son of an elder brother can practise *la hot*, 'enter the hut'. This is the Dinka levirate arrangement.

<sup>15</sup> The use of social science jargon such as polyandry in describing Nilotic marriage is problematic. I suggest that it be avoided. My willingness to use the term here is based in the knowledge that it does not reflect the intentions, the feelings or the expected outcomes of the Dinka.

neither had ever used it. They both said they have not felt the need for it. Child spacing is practised through extending the period of breast feeding, up to two years. During this time the couple sleep apart and have no sexual contact.<sup>16</sup> Although Dinka women show eagerness to become pregnant as soon as the child is weaned, perhaps primarily to please the family, they view pregnancy as a dangerous and stressful experience.

### *The sample*

As mentioned above, although the sixty women of Akon who formed the research sample were selected in a controlled mode,<sup>17</sup> and some were selected as key informants through a cultural competence test,<sup>18</sup> many more women volunteered following a meeting I held in the chief's court. At the meeting I announced the research objectives and asked the men to inform their wives that I would be visiting homes to interview people. Before my arrival in Akon there had been numerous assessment projects for relief purposes which had raised hopes among the local population of personal assistance. This presented my project with a problem, as people initially expected an immediate return for participation in the research. At the outset I emphasised that I was studying women's health in general, but the only criteria for selecting the sample were that the woman must have given birth at least once, and/or had an abortion, and/or was pregnant or trying to conceive at the time of the research. The aim was to elicit information on the kind of problems women experience in their reproductive life. A series of culturally relevant categories of information was developed around the issue of pregnancy, its accompanying problems, and women's responses to the problems. I did not emphasise to them my interest in abortion, sexuality and reproductive desires. Many men said to me, 'Since you say you are here to study women's health, you should look into the causes of miscarriages, because that is the biggest health problem facing us here'.

The ages of the sample women ranged from about 18 to about 62. The ages were assessed on the basis of historical and life events that the women could remember. The majority of the women had yet to reach the end of their reproductive capacity (completed fertility). Thirty-three per cent of women in the sample had been displaced to Akon from various areas of Gogrial and Aweil and many had spent a considerable portion of their lives over the previous seven years on the move before settling in Akon. Education and literacy were almost non-existent. Fifty-eight of the women had never been to school. The two who had attended school (the only ones in the area) were a third-grade and a fifth-grade leaver. All the women were married, but all the displaced were either alone at the time of the interview or in the care of

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<sup>16</sup> Congress between a couple while the woman is breast-feeding is taboo. It is believed that sexual contact causes health problems for the child such as diarrhoea and vomiting.

<sup>17</sup> The sample for the wider project was selected randomly to ensure representation of the communities in terms of their social status, background and demographic structure.

<sup>18</sup> In selecting key informants we administered a questionnaire to ascertain willingness and ability to philosophise beyond the mere description of suffering, length of habitation in the region and knowledge of the people.



TABLE 1 *Results of age assessments for sample women*

<i>Age category</i>	<i>No.</i>	<i>%</i>
18–21	30	50
22–30	21	35
32–40	6	10
40 or over	3	5

an in-law. Among the women from the host community, thirty-eight were in polygynous marriages, ranging from senior to fourth wives. Three were 'elderly' widows, five were 'young' widows, four of whom had entered the levirate institution. Two had been married for deceased men *by* the deceased men's younger brothers, who 'only fathered the children but were not willing/able to look after them', and nine described themselves as abandoned in favour of senior wives or by husbands who migrated to the north.

#### REPRODUCTIVE SUMMARIES

The women reported a total of 343 pregnancies, an average of 5.7 per woman. Of these pregnancies, ninety ended in spontaneous or induced abortion or still births, an average of 1.5 per woman. Only women in the age category 22–32 reported 'miscarriages'. Of the remaining 253 live births reported, seventy (27.7 per cent) died from various causes, including the under 5 years of age childhood diseases, and other diseases affecting children up to the age of 15. There were, then, a total of 183 living children at the time of study (three per woman), but many women with young children expressed their worry about the future of their infants or toddlers because of their poor nutritional condition. These women said some of their children might not survive infancy. In addition, discounting the three women in the sample over the age of 40 and an additional four women among whom three deemed themselves infertile after repeated miscarriages, and one woman who reported having refused to enter the levirate arrangement, there were still potentially fertile women in the sample. The figures in Table 2

TABLE 2 *Results from reproductive histories of sixty women showing the number of pregnancies per woman, live births, living children, abortion and deaths*

<i>Category</i>	<i>No.</i>	<i>No. per woman</i>
Total pregnancies	343	5.7
Total live births	253	4.2
Total living children	183	3.0
Miscarriages/abortions <sup>a</sup>	90	1.5
Childhood death	70	1.2

<sup>a</sup> In an effort to conceal therapeutic abortions, women call them miscarriages.

serve the purpose only of providing a glimpse of society's efforts to balance fertility and mortality rates. These efforts face the women with major reproductive suffering.

Most studies of reproductive risks in emergency zones have found that women are most vulnerable and at highest risk at the time of a raid, on capture by a rival group, and from increased child mortality. But another dangerous time observed in south Sudan is the return of the husband after a long period of absence. The rules of sexual taboo are broken because the man feels the urge to expose his wife to pregnancy before his military duties take him away again. Traditionally prescribed periods of weaning and beliefs about menstrual cycles, which are the only mechanisms of birth control, are disregarded by the man. Pressure on women to disregard the 'weaning taboo', which prohibits sexual relations during lactation, has been mounting steadily as husbands on short, unpredictable periods of military leave return home determined to conceive another child. More important, it is a time when the woman is sympathetic towards the man and less insistent on enforcing the norms. Similarly, women are being pressured by husbands and in-laws to reduce the 'fallow period' between pregnancies by weaning their infants earlier. The fact that among younger Dinka women becoming pregnant is a longed-for and desirable way of proving one's worth as a wife contributes, I believe, to the statistic that they are at greatest reproductive risk during the present emergency. Many younger women in the sample said that at this sort of time one complies and then regrets it soon after. This is due to a dilemma they are faced with. For example, in addition to the traditional desire for a large number of children, a Dinka woman who has suffered many child deaths or miscarriages is expected to become pregnant again straight away. The fear that the living children may die makes this urge even stronger. As a result, the combination of meeting the man's sexual demands, living up to the family's reproductive expectations and the lack of contraceptives forces many women to become pregnant frequently. But 35 per cent reported going along with the pressure to conceive and then terminating their pregnancies. In Dinka popular ideology the practice would be viewed with horror, yet its observed frequency is worth investigating. The rest of this article explores the dynamics of changing perceptions of sexuality and abortion and Dinka women's concepts of reproductive risk and its perceived causes.

#### *YEN ACI KOU DUONY: A FOLK DIAGNOSIS*

Dinka women spoke, covertly, of a number of symptoms that are greatly feared in childbearing and which they think cannot be treated, given the present situation. These conditions are referred to by a euphemism, *duony kou*, 'broken back', in order to avoid saying the dreaded names of the many folk sicknesses associated with pregnancy and childbirth.<sup>19</sup> It is striking how

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<sup>19</sup> 'Lack of blood in the body' (anaemia), eclampsia/hypertension, obstructed labour, and infant care were repeatedly mentioned as most dreaded possibilities in childbearing.

often it is stressed that they are not new but that inability to treat them is a direct result of the war and lack of family support. Most informants volunteered that a woman who regarded herself as suffering a 'broken back' from frequent pregnancy would do best to take matters into her own hands, meaning that if she could not control the sexual decision she could at least control the outcome. It meant, quite simply, not carrying to full term a pregnancy unwillingly conceived.

*Duony kou* may refer to any ailments that result from heavy labour during pregnancy, pregnancy without proper nutrition or breast-feeding a child that is possibly going to be malnourished. The conditions that should alert women to the possibility of *duony kou* include the absence of a husband to aid in food production, lack of milk cows, the number of children born and displacement. I suspect that, since this folk diagnosis is named by a euphemism known only among women, it allows them a great deal of latitude in deciding which pregnancy to carry to term and which to terminate. The decision is most certainly made without consulting the husband. The following quotation illustrates the point:

Terminating a pregnancy is thought of in our society as the biggest sin, so we don't talk about it except in a circle of friends who trust each other. It is therefore necessary to use a term that actually means suffering from heavy work. But for women, pregnancy, taking care of the household and hunger—could anything else be heavier? So you can be sitting among a lot of people and you still talk about abortion in terms of heavy work and no man will have a clue. This is not to say that women are proud of practising abortion. It is not the easiest thing to do, but it is the only option we have got. It takes a lot of courage to do it, and the pain from it lives with you for the rest of your life.

The more I heard women describe the hardships brought upon them by war in terms of *duony kou* the clearer it became that they were describing not only the expenditure of energy in the fields but the symptoms of reproductive health problems caused by frequent pregnancies and abortion complications.

#### REPRODUCTIVE DECISIONS AND COVERT PROTEST

Many conditions in Akon are hostile to women's reproductive well-being. Most serious are the ones I have mentioned only in passing: soldiers' sexual demands, high rates of infant death, lack of health-care facilities and the spread of untreated STDs and other infections. I have chosen to focus on aspects of women's beliefs and reproductive behaviour that may also contribute to reproductive risks in order to address the indignities and inhumanities forced upon war-zone women, who must at times make choices and decisions that no woman should have to make. 'How can I run the risk of another pregnancy and childbirth when I can't even feed the children I already have?' 'Should I attempt to abort, knowing many other women have died or become infertile because of the process?' 'How would my husband and his family react if they found out that I had aborted their child?' 'Is God going to punish me for taking such a serious matter into my own hands?' It should be clear from the foregoing that the reproductive risks women face are a direct consequence of the civil war. The deaths of children are caused

by the upheaval of war, and therefore society urges women to procreate and make up the loss. They are also a consequence of the appalling economic conditions associated with displacement and the uprooting of social support networks. Nowhere, perhaps, are the links between social disruption and women's reproductive risks more apparent than in the brief history of the precipitous breakdown of the social norms that governed sexual and reproductive decisions among the Dinka and women's own explanatory models to account for reproductive risk.<sup>20</sup>

There appears to be a direct correlation between social disruption and reproductive risk in the war-affected populations of the world. Yet it is widely documented that under the more chronic conditions of unrest a generation of childbearing women is less likely to maintain the traditional knowledge about reproduction. This is especially true among rural women displaced to relief centres, where the kind of social support available to them is inimical to reproductive well-being.

The preliminary survey data showed that 'miscarriages' were a major public health issue. Abortion under circumstances of war and displacement would undoubtedly be a health crisis in a Dinka community. For one thing, it is morally unacceptable and illegal; for another, it is unsafe, because it occurs under the most furtive and unhygienic conditions. From reported cases of 'excessive menstrual bleeding' which turned out in our follow-up interviews to be induced abortions—self-reported cases and those reported by relatives—we counted a total of 130 miscarriages and terminated pregnancies in a year and a half, seven of which ended in death over eight months in a population of 23,000 people. Yet it is my belief that the women under-reported abortion. Among some of the younger ones initial reluctance to discuss abortions was observed. A traditional birth attendant (TBA) explained why unsafe abortion is a major cause of maternal mortality, infertility and other reproductive risks. 'I have seen it causing immediate complications.' The complications result from the use of unsterilised instruments, failure to perform a complete abortion, puncturing the cervix, uterus or other organs, which causes bleeding, or from later maternal sepsis. Death from abortion complications or miscarriages account for 28 per cent of maternal deaths in Akon, as is shown in Table 3. During this project in 1994, we systematically recorded monthly deaths in Akon by cause, and Table 3 shows the percentage of abortion-related deaths.

But why do women have to terminate pregnancy? In Akon, as may be the case in other parts of south Sudan, abortion is a function of changed household structure and the negotiation of gender-based power relations. In Western Dinka one primary explanation is that pregnancies ensue from the illicit sexual relations of married women and from premarital sex (in the case of girls). Of the 130 'miscarriages' or abortions recorded, thirty-eight were

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<sup>20</sup> I acknowledge that what Dinka women are experiencing today may be simply a continuation of things that have existed in their culture all along. However, owing to war, a normal process of change has increased in pace beyond their readiness to accept and deal with change.

TABLE 3 *Results of monthly maternal death recording*

<i>Month</i>	<i>No. of maternal deaths</i>	<i>Abortions</i>	
		<i>No.</i>	<i>%</i>
January	4	2	50.0
February	2	—	—
March	2	2	100.0
April	5	2	40.0
May	2	—	—
June	7	1	14.3
July	3	—	—
August	—	—	—
Total	25	7	28.0

found to have been performed solely because the woman did not want more children, and at the risk of jeopardising her marriage and reputation. Our interviews about sexual behaviour have revealed a variety of sexual relations in Akon between displaced women and soldiers, between women whose husbands were at the war front or had migrated to the north in search of economic opportunities, and between adolescent girls and adult men. Women also reported selling unprotected sex. When such relations (except sex work)<sup>21</sup> result in pregnancy there is fear of social consequences such as marriage breakdown, inability to find a suitable match, or the loss of property that the woman's family had received as bridewealth. The woman chooses to terminate before it is discovered.

At the relief clinic the predominant health problem among women of reproductive age was abortion or miscarriage and its complications. There were women who attended the clinic as soon as the bleeding started, those who came in when they had lost the baby but were still haemorrhaging and those who were still feeling pain in the cervix or other organs and sought treatment for a suspected infection. Most such cases were reported to the clinic as spontaneous, but during our long-term follow-up over months of intensive interviewing we found that many of them had been induced. The first group tend to be those who believe less in traditional methods of stopping the bleeding. Some of them get help and the bleeding stops before it is too late, if indeed it was spontaneous. The latter two groups wait or resort to traditional ways of stopping it.

Spontaneous bleeding during the first trimester is believed to have roots in the supernatural, and it is unlikely to be remedied by means other than

<sup>21</sup> Sex workers in Akon are not necessarily self-described prostitutes. They also fear for their reputation and want their share of the Dinka notion of womanhood: decent marriage and children. Unfortunately, more immediate needs are at stake, and that pushes some women to the sale of sex.

communicating with the spiritual world. Among the things people do to initiate such communication and treatment is asking a woman who has given birth to twins in the past to tie a rope round the bleeding woman's waist or ankle. That should stop the baby from 'coming out'. Others include giving the woman a special substance to ingest if it is suspected that she has trodden in the footprints of someone who has had an abortion or miscarriage in the recent past, a factor that is believed to be detrimental to other pregnant women. A substance called *nyor* may also be burnt like incense and put next to the woman for her to smell or be placed in an amulet case for her to wear round her neck. It is noteworthy that women who have just conceived are advised not to walk on the main road, at least during the first trimester, when the baby is still a 'mere blood'. Some women in Akon said that their husbands had forbidden them to go to market from worry that the 'prostitutes' who frequent the market place often get pregnant and terminate, so that it would be risky for a pregnant woman to go there barefoot. Out of courtesy women who have suffered a miscarriage avoid the main footpaths so as not to inconvenience others. When we asked the women whether footprints could be used to terminate pregnancy no one seriously thought they could. It is interesting to note that the perceived causes of miscarriage, which included various therapeutic agents, emphasised heavy labour, infection, poor diet and the lack of health advice as likely causes, but not included the seemingly easy alternative of walking on someone's footprints.

So how is the induced abortion performed and by whom? Women explained that ingesting any bitter root such as that of the mahogany tree is capable of upsetting the uterus, disturbs the foetus and can eventually expel it. An overdose of chloroquine or any other anti-malarial drug is deemed the quickest technique.<sup>22</sup> In the absence of such knowledge, women may resort to mechanical means such as exerting physical pressure on the belly or the back, playing rough, bending down abruptly, lifting heavy items or, more treacherously, inserting a thin object such as the stem of a leaf through the cervix. In short, under conditions where safe traditional knowledge or medical abortion is lacking women constantly experiment with various unsafe methods, and there are no particular specialists in abortion.

Acok Bol, who had learned about abortion from personal experience, had 'helped' many women to obtain abortifacients. She told of one such case:

My friend who got pregnant by a man other than her husband came to me seeking advice on how to terminate her pregnancy. She knew that I was not an expert. I told her that the procedures that I know of are purely experimental and very risky, that she could be killed if we cannot stop the bleeding afterwards, and that she risks being found out if she falls ill from it . . . and she was determined to go ahead with it because she did not want to jeopardise her marriage. We tried various methods that I know of, and none of them would work. At first, I gave her the powder of a bitter root to dilute and drink. We waited for two days and nothing

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<sup>22</sup> Because chloroquin tablets are potentially toxic, especially if taken in higher than recommended doses, they are capable of causing abnormality in the foetus.

happened. Then we started hard physical activity, including playing, giving her a punch in the stomach and heavy labour. We told her other friends to help and we provided her with heavy doses of chloroquine, then *zahas*, a blueing powder for white garments. None of them worked for her, although they often do, and a lot of women are quite familiar with them around here.

This woman's baby was born with deformities resembling the signs of foetal alcohol syndrome, including the downward slant of mouth and eyebrows, walking on tiptoe and slow development. Stories of children surviving abortion attempts are legion. Some are said to have been born with scars on the forehead, underweight and never healthy during childhood. When children are born with such marks people speculate about attempted abortion and there are whispers about their mothers as 'bad'. Yet women do what seems best, however perilous the means they have access to.

One woman stated her determination but concluded with a grim outlook and an apparently traumatic experience:

What can I say about this abortion thing? First of all I feel pleased with myself for having had the courage to do it. I just said to myself, 'No I don't want to go through another painful pregnancy, not at this time in my life, when nobody is able to help,' and I don't care what people say. They don't usually have anything to say when you need help, but you hear them say a lot when you try to live your life as best you can . . . I said, if people ask me about it I'll tell them it was spontaneous, and nobody will doubt me on that because people in this society still consider induced abortion as unthinkable. Why should I want to have abortion? I also asked myself, 'So what if my husband finds out? What is he going to do? Divorce me?' Well, I'm better off divorced than deceiving myself about a marriage that does not exist, does not provide what it should. The only problem with abortion is that it could kill you. If you survive physically, it kills you inside. A slow and painful death, that you feel eating away your energy every day. Ever since I have asked myself if the decision was absolutely necessary. I have got to grips with life pretty much on the surface, I can laugh and joke around with everyone, but most people don't know about the fire burning inside me . . . I always have nightmares about being punished by God so that I can't have more children when I need/want to. My biggest nightmare is when bad thoughts come into my head . . . like what if I lose my older children and then realise that I've been punished and I can't have any more. I usually feel the spirits coming to me when I'm walking alone, asking me what am I worth as a woman if I can take into my own hands something that is supposed to be their responsibility: to bear or not to bear children . . . I can't stop feeling this way, because I find my friends with similar experiences talking about having the same sentiments.

It is interesting to note that she is aware of the possibility of post-abortion infertility but attributes it to supernatural wrath, and not to the complications of the procedure.

It is clear that abortion is really the only resort for women who have no desire for more children, because they can hardly prevent pregnancies otherwise, since they are bound both by family tradition and by the costs of war not only to procreate but also to render sexual services. The latter remove the only possible way of avoiding the agony of having to decide whether or not to terminate pregnancy, and that is abstinence. Women hardly

have the option of 'refusing the hut'<sup>23</sup> because resistance to sexual demands is not taken seriously. Most men in Western Dinka think that women have a boundless appetite for sex. They think that when a woman says 'no' she is either angry about something or just trying to appear modest instead of showing some inclination for 'it'.<sup>24</sup> Male persistence will only increase her desire. 'When a woman says no, she doesn't mean a bit of it,' men will say. This is the legacy of a communication gap between men and women that has far-reaching consequences for women's health.

In line with Foucault's concept of practices of repression (1980: 79), women believe this is the kind of way in which they lose their power. However, the hegemonic ideas about the household, sexuality, childbirth and control of resources propagated by the dominant ideology (men's) are negotiated and emended by those who are subordinate (women in this case) in line with their own experience and understanding. The process is as likely to be unconsciously triggered by a desperate situation as intentional. Therefore, in the midst of suffering due to gender differentials and the violence of militarised youth, women find avenues of resistance and coping.

#### CONCLUSION

It is my contention that the community-level gender differentials in sexual decisions and the micro-level reproductive decisions of women interact with the despair of women who are at least partially resigned to community fertility patterns to give rise to a high expectation of terminating pregnancies. Studies of the effects on reproduction of war and subsequent rapid social transition in the 'developing' world have tended to focus on the most obvious aspects (statistics of rape, destruction of health services, increased work load) to the neglect of the silent suffering within families and local communities. Yet it is in the realm of individual experience that human motives are most profoundly driven by the need to negotiate and resist. Both the internalisation of reproductive norms and the projection of a psychology of balancing between the norm and personal beliefs about well-being are expressed in Dinka women's reproductive risk of infertility, infection and other complications entailed in abortion, and in their perceptions of women's worth.

It is also within the domain of individual experience that these women are beginning to struggle with awareness of the connections between their suffering, on the one hand, and community-level gender relations and the military environment on the other. Women hope that when they sleep under a tree in the rainy season or queue for a whole day in steamy heat to obtain food rations, their faces ravaged by the upheavals of war, it will send a

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<sup>23</sup> The phrase is a metaphor for rejecting the levirate practice or the ordinary marital sexual contact. Dinka women do not feel free to refuse their husbands sexual access on demand for fear of a beating. The woman also fears that her husband will consider her disloyal, or even perhaps unfaithful, an accusation equally detrimental to the marriage.

<sup>24</sup> The 'it' refers to either the sexual contact itself or the penis.



message to community leaders that their struggles are as important as men's. And so most reproductive decisions should be expected to be the woman's because they are as much a health risk, with her shouldering most of it, as a political or economic risk.

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#### ABSTRACT

Studies of reproductive risk under war conditions pay a great deal of attention to statistics of sexual violence inflicted by one warring party upon women of the other. While such attention is justified, it mystifies the risk contained within families and local communities. This article examines the effects of the militarisation of youth in southern Sudan on women's reproductive well-being. The war has caused families to desire many children to make up for the high wartime infant mortality rate. The resultant social breakdown has prompted men to breach the rules of sexuality and sexual taboos to such an extent that women have lost much control over sexual and reproductive decisions. Women in Western Dinka, therefore, agree to conceive unwillingly. They also regard pregnancy as a difficult ordeal. Many, however, terminate pregnancy with unsafe techniques that risk infertility, infection or death.

#### RÉSUMÉ

Les études sur les risques pour la santé reproductive en temps de guerre s'intéressent beaucoup aux statistiques en matière de violence sexuelle infligée par une des parties belligérantes aux femmes de l'autre partie. Bien que justifié, cet intérêt obscurcit les risques présents dans les familles et les communautés locales. Cet article examine les conséquences de la militarisation des jeunes dans le sud du Soudan sur la santé reproductive des femmes. La guerre a amené les familles à désirer plus d'enfants pour compenser le taux élevé de mortalité infantile en temps de guerre. La rupture sociale entraînée par la guerre a incité les hommes à enfreindre les règles de la

sexualité et les tabous sexuels à un point tel que les femmes ont perdu une grande part du pouvoir décisionnel qu'elles avaient sur leur sexualité et leur reproductivité. Ainsi, dans la région occidentale de Dinka, les femmes acceptent de concevoir contre leur gré. Elles considèrent également la grossesse comme une épreuve difficile. Nombreuses sont celles cependant qui tentent d'interrompre leur grossesse par des techniques dangereuses pouvant entraîner une infertilité, des infections ou la mort.