Maternal Health in Ethiopia: Global and Local Complexities

by

Yamrot Girma Teshome

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Approved April 2017 by the
Graduate Supervisory Committee:

Ann Hibner Koblitz, Chair
Karen J. Leong,
Lisa M. Anderson

ARIZONA STATE UNIVERSITY

May 2017

ABSTRACT

WHO estimates that 830 women die every day due to maternal health complications. The disparities in maternal health are unevenly distributed between wealthy and poor nations. Ethiopia has one of the highest mortality rates in the world. Existing high maternal mortality rates worldwide and in Ethiopia indicate the shortcomings of maternal health interventions currently underway. Understanding the socio-cultural, economic and political factors that influence maternal health outcomes locally while simultaneously examining how global reproductive and development programs and policies shape and influence the reproductive needs and knowledge of women is important. Employing feminist and African indigenous methodologies, in this research I explore maternal health issues in Ethiopia in two of the largest regions of the nation, namely Oromia and Amhara, more specifically in Seden Sodo and Mecha districts. Using qualitative interviews and focus group discussions, I examined the various socio-cultural, political and economic factors that influence maternal health outcomes, assessing how gender, class, education, marriage and other social factors shape women's health outcomes of pregnancy and childbirth. I also explored how global and local development and reproductive health policies impact women's maternal health needs and how these needs are addressed in current implementation strategies of the Ethiopian health system. Recognizing women's social and collective existence in indigenous African communities and the new reproductive health paradigm post-ICPD, I addressed the role of men in maternal health experience. I argue that global and local development and reproductive policies and their implementation are complex. While comprehensive descriptions of national and maternal health policies on paper and gender-

sensitive implementation strategies point toward the beginning of a favorable future in maternal health service provision, the global economic policies, population control ideas, modernization/development narratives that the nation employs that focus on biomedical solutions without due emphasis to socio-cultural aspects have a detrimental effect on maternal health services provision. I advocate for the need to understand and include social determinants in policies and implementation in addition to legal enforcement and biomedical solutions. I also argue for alternative perspectives on masculinities and the role of men in maternal health to improve maternal health service provision.

DEDICATION

I dedicate this work to my late grandmother Kebebush Woldemichael who in the 1950s, challenged rural community elders about their patriarchal views about women's education and livelihood, I am standing on your shoulders.

ACKNOWLEDGMENTS

First, I would like to thank the women and men of Andenet and Mudena Ibayyuu Kebeles in Amhara and Oromia regions for sharing their experiences with me. I have been humbled by your wealth of knowledge and hospitality during my field work. I am very grateful to the women and men who had spent their valuable time with me during the interviews. I would also like to thank the Ethiopian Federal Ministry of Health, the Regional Oromia and Amhara Health Bureaus, and Mecha and Seden Sodo Woreda health offices for their support and cooperation. I would also like to thank the two health extension workers and road guides from both regions who have helped me identify research participants. My research assistant and translator Lemi Negeri and Abebe Negeri in Oromia and Aragaw Lamesgin in Amhara region, thank you for your time and hard work. *Betam Ameseginalehu! Galatoomi!*

I would like to extend my gratitude to WGS professors for their nurturing academic spirit and for providing me with the necessary analytical tools to conducted a well-rounded feminist research. I would especially like to thank my advisor and dissertation committee chair, Professor Ann Hibner Koblitz. Your valuable and prompt feedback and diligent effort and support for my work, your mentorship and guidance throughout the past five years has been invaluable. I have learned a lot from you and from your thorough analysis and well-rounded feminist critique of global reproductive politics and development. Thank you! I would like to thank Dr. Karen Leong and Dr. Lisa Anderson, my dissertation committee members for their unwavering support throughout my study and their mentorship in my academic and personal life and, for their valuable comments and intellectual inputs in this research. I have genuinely witnessed

and experienced a feminist academic and social space and support here at ASU because of all three of you. Thank you! I would also like to thank Dr Mayla Vicenti Carpio for the indigenous feminist perspectives that have shaped my work and for her academic and social support. Victoria Namuggala, Dilofarid Miskinzod, Deborah Ayodele and Sakena Young-Scaggs, thank you for your support and friendship. This work would not have been possible without the financial support of Arizona State University, School of Social Transformation, Women and Gender Studies department, PEO/IPS and the Graduate Education College Year-long Dissertation Fellowship. The fellowship opportunity allowed me to successfully complete my dissertation write-up.

Finally, I thank my creator Egziyabher for my life and my family for the meaning they have given to it. My mother, Aynalem Teklegiorgis who has given her all to make me the person I am today and whose lived experiences and knowledge has shaped my feminist thinking. Your support has been invaluable, thank you. My father Girma Teshome, you are the embodiment of intellectual wealth for me. You are a living and walking library where I have learned many things and you have shaped my thinking in so many ways. I thank you and my brother Darius Girma for your diligent support in this research. My brother Mekdem Kebede and my sister Martha Negusse thank you for your morale support. My husband Abel Alemayehu Kebede, I thank you for your patience and encouragement in the past five years and for helping me apply to this PhD program. I am truly grateful. My son Raey, you were an inspiration and motivation when I was writing this dissertation. Thank you all and much love!

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

Overview

> For us, obstetricians and midwives who serve the health needs of women in under-served regions, maternal mortality is not statistics. It is not numbers. It is not rates or ratios. Maternal Mortality is people. It is women, women who have names, women who have faces and we have seen these faces in the throes of agony, distress, and despair. They are faces that continue to live in your memory and haunt your dreams. And this is not simply because these are women who die in the prime of their lives, at a time of great expectation and joy. And it is not simply because a maternal death is one of the most terrible ways to die, be it bleeding to death, the convulsions of toxemia of pregnancy, the unbearable pangs of obstructed labor, or the agony of puerperal sepsis. It is because in almost each and every case, in retrospect, it is an event that could have been prevented. It is an event that should never have been allowed to happen. It is an event that bears and should bear so heavily on our collective conscience. (Dr. Mahmoud Fathalla, World Health Day, April 7, 1998, cited in Anderson, 2009, p.1)

Fathalla's speech above vividly describes the agony of many women worldwide who have lost their lives as a result of a preventable health condition. Maternal health complications are among the gravest global health challenges today[1]. The World Health Organization (WHO) estimates that 830 women die every day (WHO, 2016). The disparities in maternal health are distributed unevenly between wealthy nations and countries lacking resources. WHO notes that maternal mortality is higher in women living in rural areas and among poorer communities (Ibid). "Developing" nations account for 99% of the maternal death rates with more than half of the deaths taking place in Sub-Saharan Africa (Nasah et al., 1994; WHO, 2016). "Nigeria, India, Pakistan, Afghanistan, Ethiopia and the Democratic Republic of Congo currently account for 50 percent of the

[1] The World Health Organization (WHO) defines maternal health as "the health of a woman during pregnancy, childbirth and the postpartum period WHO. (WHO, 2017). Women and health. (n.d.). Retrieved from http://www.who.int/gho/women_and_health/en/index.html

total global estimates of maternal mortality" (Bazuaye & Okonofua, 2013, p.9). The death rates in Africa remain high, 1 in 40 women compared to 1 in 33,000 in Europe. If maternal death and complications are indeed "preventable," why has the world then allowed such tragedy to happen and why have maternal complications and death not been prevented?

In the 1980s maternal mortality was termed a "neglected epidemic" (Anderson, 2009; Pacagnella et al., 2012). Despite the shocking rates of women dying from what is mostly a preventable phenomenon, various authors affirm that maternal health complications and maternal mortality were not recognized as a serious challenge globally until the 1980s (Anderson, 2009; Nasah et al., 1994; Pacagnella et al., 2012; Petchesky, 2003). One major reason for the lack of emphasis on maternal health that various scholars have noted is that the reproductive health policy focus globally was and still is on family planning programs as a preventive, cost-effective measure and as a population control strategy to limit and control the fertility of women (Hartmann, 1995; Petchesky, 2003). The consensus globally about maternal health is that preventive measures of family planning practices such as the provision of contraceptives and health-facility based child delivery with skilled birth attendants can stop maternal deaths. This consensus is primarily due to universalized, global and local reproductive health policies, biomedical and development narratives and assumptions that only promote the medicalization of childbirth and the regulation of fertility as preventive measures (Conrad, 2007; Federal Ministry of Health of Ethiopia [FMOH], 2006; Glenn et al., 1994; Hartmann, 1995; Prosen, 2014; Takeshita, 2012). This homogenous solution does not take into account

social, economic and political contexts and the reproductive desires and needs of many women (Glenn et al., 1994; Hartmann, 1995; Takeshita, 2012).

In addition, the fact that 99% of maternal deaths occur in the developing nations explains the lack of emphasis given to these lives globally and the reasons why maternal health has not been a global health priority for many years. The geopolitical spaces where maternal deaths occur determines what Butler explains as the "grievability" of the lives lost and the recognition afforded for maternal health complications (Butler, 2004, p.24). Injustice in the form of wealth and resource inequalities between nations and among groups has a lot to do with how maternal health is addressed globally and nationally (Grown et al., 2006). Power relations in a globalized economic system influence the availability of comprehensive, basic and emergency obstetric and reproductive health services (Grown et al., 2006; Petchesky, 2003). Brundtland, a former Director-General of WHO, in 1998 firmly called out the world's collective failure in solving the tragedy of maternal mortality and explained maternal health conditions as a reflection of the "suffering and injustice in our societies"[2].

As one of the developing nations, Ethiopia ranks among the countries with the highest maternal mortality rates in the world (Bazuaye & Okonofua, 2013). There are some inconsistencies in the data estimates provided by the government and the WHO. The last Ethiopian Demographic and Health Survey (DHS) in 2011 shows maternal mortality figures of 676 deaths per 100,000 live births, with current United Nations (UN), WHO estimates of 420 and the FMOH estimates of 590 per 100,000 live births (CSA,

[2] Fathalla, F, M. (2000). Imagine a world where motherhood is safe for all women: We can help make it happen. Lecture and presentation at the Hubert de Watteville memorial lecture FIGO World Congress, Washington D.C. (p. 4)

2012, FMOH, 2015a). However, a recent study that focused on the trends and causes of maternal mortality in Ethiopia from 1990-2013 showed no significant change in maternal mortality rates in the study period. The lack of significant change in maternal mortality rates demonstrates that Ethiopia has not made substantial progress. Similarly, recent small-scale community-based and hospital-based studies conducted in all the regions of the nation showed that there had not been a significant change in maternal health in the past 30 years (Berhan & Berhan, 2014; Tessema et al., 2017).

In the past two decades government and non-governmental organizations in Ethiopia have established numerous maternal health strategies and interventions. Ethiopia has incorporated into the national health policy various global health and development initiatives. These initiatives range from the global pledges of the Primary Health Care for all at Alma Ata in 1978 and the Millennium Development Goals (MDGs) to reduce maternal mortality rate by three-fourths by the year 2015, to Safe Motherhood Campaigns and local reproductive health strategies to address maternal health complications (Adjiwanou & LeGrand, 2014; Anderson, 2009; Johnson, 2014).

Global biomedical, modernization and development narratives that promote the medicalization of childbirth and regulation of fertility as preventive measures are quite pervasive in the policies and strategies of the nation. The National Health Policy, Reproductive Health Strategy and the Population Policy of Ethiopia primarily focus on family planning, skilled birth attendances, and providing women with the education and information to address maternal health concerns (Federal Ministry of Health [FMOH], 2006, 2015a). However, numerous studies show that the majority of the communities in Ethiopia continue to use traditional health practices despite the push for biomedical

solutions and health facility-based interventions in maternal health (Kassaye et al., 2006; Mehari et al. 2012; Getahun & Balcha; 2012). Many women in Ethiopia for various reasons still deliver at home despite the promotion of facility-based delivery (Alemayehu & Mekonnen, 2015; FMOH, 2010; CSA, 2012; Roro et al., 2014; Shiferaw et al., 2013; Sipsma et al., 2013). Besides, many women in Ethiopia are still not using modern family planning methods (CSA, 2012). High maternal mortality rates, women's preference to deliver at home, and low use of family planning suggest that the interventions in place have not been successful in reducing maternal health challenges (CSA, 2012).

Apart from some small-scale studies, the national demographic and health surveys and other government health information systems that provide relevant statistics on maternal health issues have not conducted an in-depth analysis of why maternal complications and deaths continue to occur. In addition, many studies discuss maternal health causes mostly in terms of direct obstetric complications and indirect pre-existing medical conditions resulting in maternal morbidities and mortalities and the biomedical solutions to mitigate them (Abdella, 2010; Flippi, 2009; Pacagnella et.al, 2012; WHO, 2013). Globally and nationally the top five direct causes of maternal health issues include hemorrhage (uncontrolled bleeding resulting in 25% of the deaths worldwide), sepsis/infection (15%), unsafe abortion (13%), severe pre-eclampsia/eclampsia (hypertension leading to seizures) (12%) and obstructed/prolonged labor (12%) (WHO, 2015; Berhan & Berhan, 2014; Pacagnella et.al., 2012). In Ethiopia, HIV/AIDS, malaria, tuberculosis, hepatitis, influenza, other infectious diseases, heart failure, anemia, and malnutrition worsen maternal health complications (Berhan &Berhan, 2014; FMOH, 2006; Tessema et at., 2017).

Even though these direct and immediate causes are significant and result in actual maternal morbidities and mortalities, these circumstances are related to underlying socio-cultural, political and economic factors and women's status in society (FMOH, 2006; UNFPA, 2008). For instance, long-term morbidities such as obstetric fistula, chronic pelvic pain, depression, fatigue and hypertension result from and are exacerbated by women's pre-existing social and economic conditions (Ibid). Major underlying social causes of maternal health complications outlined so far in various studies including this one include: poverty, lack of education and information, socio-cultural factors such as early marriage and traditional practices, gender relations between men and women and lack of women's autonomy and decision-making (Dudgeon & Inhorn, 2004; Gurmu & Dejene, 2012; Pacagnella et.al, 2012; Tessema et al., 2017; UNFPA, 2008). Studies have also discussed unavailability of health facilities and infrastructure such as roads, lack of financial resources and health care professionals and distance to health facilities as socio-economic and political factors inhibiting women and their communities from delivering in health facilities (Shiferaw et al., 2013).

Social, economic, and political factors together inform maternal health experiences of Ethiopian women. However, government-designed solutions to address these social, economic and political conditions are often framed through biomedical and development intervention narratives that seem to treat social maternal health issues as only a medical or legal challenge without paying attention to the reality on the ground. There is a lack of thorough examination nationally of women's actual needs and desires related to maternal health issues. Specifically, there are few studies inquiring about women's choice to deliver at home or examining the underlying cultural and social

dimensions to pregnancy and childbirth from the perspective of women and their community (Bedford et al., 2013; Roro et al., 2014; Shiferaw et al., 2013). National surveys have not examined the various social dimensions that influence women's decision to deliver at home or why and how women give birth in such situations (CSA, 2012; FMOH, 2006).

Numerous studies have also shown that reproductive health programs in Ethiopia are women-focused, considering women as the sole responsibility-bearers of maternal and reproductive health concerns in a context where men and other family members culturally make the majority of the family health decisions. There is a dearth of knowledge about men influence health decision making and about their role in maternal health issues (Dudgeon & Inhorn, 2004; Sharma, 2003).Various texts affirm that maternal health programs and policies in the developing nations at large simply focus on educating women about maternal health care issues without due regard as to who makes the household decisions (Alva, 2012; Dudgeon & Inhorn, 2004; Harkiran & Seema, 2013; Plantin et al., 2011; Sandisky, 2011). Moreover, the gender constructions of international and development programs that seek to support women in third world nations have been problematic where gender is conceptualized based on the western nuclear family model that fails to appreciate the complexities of extended familial ties.

The Study at Hand

Current high maternal mortality rates worldwide and in Ethiopia and women's delivery at home attest to the ineffectiveness of maternal health interventions underway. There is an urgent need to understand the socio-cultural, economic and political factors that influence maternal health outcomes at the local level while simultaneously

examining how global reproductive and development programs and policies shape and influence the reproductive needs and knowledge of women. Guided by feminist and African indigenous methodologies, in this research I explore maternal health issues in Ethiopia in two of the largest regions of the nation, namely Oromia and Amhara. My work specifically focused on Seden Sodo Woreda (District) of Oromia and Mecha Woreda of the Amhara regions and Mudena Ibayyuu and Andenet Kebeles (smallest unit of government administration within the districts)[3] of the Woredas respectively (See Appendix B for Regional and Woreda maps).

My research investigates how gender relations, age, class, education, marriage, religion and other social factors shape women's health outcomes of pregnancy and childbirth. I primarily asked women about their reproductive and maternal health desires and needs in the context of their socio-cultural and economic circumstances. I also sought to understand how global and local reproductive and economic development policies, programs and implementation that are currently in place address these maternal health needs and desires. I raised questions about what it means to have or want a child for women and the community. I inquired about the context in which women decide to have or prevent pregnancies and the use of family planning services. I sought to understand the social and cultural context in which women become mothers and females become women and whether this has been addressed in maternal health service provision. I also explored the involvement of men in maternal health experiences and the constructions of masculinities in maternal health programs and policies. Lastly, looking to find solutions

[3] Groups of households or families make Kebeles (Wards) which on average consist of at least five hundred families, or the equivalent of 3,500 to 4,000 persons. A collection of Kebeles makeup a Woreda. Woredas are third level administration units of the Ethiopian government, a collective of Woredas make up Zones which in turn make the Regional states of the Federal government of Ethiopia. Regions are divided by ethnic representations in the Federal Democratic Republic of Ethiopia (CSA, 2012).

and make recommendations, I inquired about pre-existing survival strategies, support systems and coping mechanisms that women utilize in their communities during maternal health complications and difficult circumstances.

Feminist and African Indigenous Epistemological and Methodological Perspectives

Women's reproductive experiences have been central to feminist scholarship especially from the 1960s and 1970s onwards (Ginsburg & Rapp, 1991). Feminist studies and feminist scholars across different disciplines have made great contributions to our current understanding of reproductive health both within and outside the field. In this section, I discuss a combination of feminist and indigenous epistemological and methodological perspectives, namely transnational, intersectional, African feminist and indigenous methodologies that allowed this study to be better grounded to explore maternal health issues of women in Ethiopia.

One crucial aspect that is important to take into account when studying maternal health issues in the Global South and specifically in Ethiopia is the need to recognize the experiences of women resulting from multiple, interlocking identities and social structures and refraining from homogenously categorizing their experiences. Two distinct feminist perspectives have challenged the homogeneity of women's experiences - intersectionality and transnational feminism. Intersectionality is a US feminist epistemology and methodology that focuses on varied and complex experiences of women on the basis of multiple and interlocking social identities and structures (Collins, 2000; Crenshaw, 1989; Shields, 2008). US Women of color feminists in the 1980s pointed out the blind spots of dominant feminist scholarship that fails to account for multiple and interlocking oppressions of women on the basis of their multiple social

identities of gender, race, class, sexuality and other categories (Collins, 2000; Crenshaw;1989; Lorde, 1984). Women of color challenged white middle-class women's account of womanhood and oppression on the basis of gender as the only salient category (Collins, 2000; Lorde, 1984). Intersectionality has thus changed how gender is analyzed in research, revealing that gender as a category functions in relation to other social identities and that it may not always be the salient category as compared to other identity markers in different socio-historical contexts (Alcoff, 2006; Shields, 2008). This methodological framework thus allows us to examine previous and current western assumptions in maternal health research and programs conducted elsewhere. International development and reproductive health programs operating in many African nations for instance have assumed gender to be a universal salient category that impacts women's reproductive health across the globe, when in reality other identity categories and the processes of globalization, development and other factors simultaneously impact their reproductive lives and may even be more salient (Oyeumi, 1997). Similarly, this methodology has allowed me to identify how Ethiopian maternal health implementation policies failed to recognize age as a salient marker in establishing innovative, gender-sensitive health approaches to address maternal health (see chapter three, p. 98).

Intersectionality primarily values the knowledge of those who are oppressed and values subjugated knowledge gained at the intersection of oppressions of race, class and gender and other factors (Collins, 2000). A feminist intersectional analysis values lived experience as a source of knowledge and seeks out the knowledge of subjugated groups not only in academic spaces but also in the everyday experiences of women (Collins, 2000; Lorde, 1984). It is thus significant and applicable to historically, economically and

politically subjugated women in the context of Ethiopia. The majority of Oromo and Amhara women in Ethiopia like other women in the Global South live in rural areas far from the academic spaces and the dominant forms of knowledge production and dissemination (Chambers, 1983). Hence, feminist theory that values and engages women's informal networks, and traditional knowledge transferring mechanisms specifically related to childbirth and other maternal health issues is useful when conducting maternal health research in Ethiopia.

The other feminist methodology that was useful in understanding maternal health experiences of women in Ethiopia along with other social, economic and political processes is transnational feminism. Transnational feminist thought critiques western feminisms' universalizing assumptions of gender that do not apply to the local experiences of women elsewhere. More specifically, transnational feminists oppose dominant western feminist discourses about third-world women that are mostly constructed based on white western feminist standards of womanhood and ideas of liberation (Gilmore, 2005; Kozol & Hesford, 2005; Mohanty, 2003; Narayan, 1997; Smith 2012). Western feminist narratives continue to represent women in the Global South as passive victims of violence, as universal dependents and victims of colonial, economic and development processes waiting to be rescued by the west/western "sisters" (Kozol & Hesford, 2005; Mohanty, 2003). Transnational feminists, therefore, challenge the construction of the universal category "woman" and notions of "global sisterhood" that universalize victimization and deprive third world women of their agency and resistance (Mohanty, 2003). In addition to destabilizing universalized categories of analysis, transnational feminism more broadly critiques the power-knowledge nexus and

the binary construction that promote hierarchical knowledge productions and Euro-American/ western dominance over other cultures (Mohanty, 2003; Shiva, 1988/2010; Smith, 2012). Hence, binary narratives of progress and development and underdevelopment, modernization, civilization and primitivism, fundamentalism and secularism, the global and local are critically examined and deconstructed (Alarcon & Moallem; 1999; Kaplan & Grewal, 2001; Moallem, 2005; Shiva, 1988/2010; Smith, 2012).

Transnational feminist methodology is applicable to maternal health research and interventions where binary forms of knowledge production prevail. For instance, medical health professionals mostly consider home delivery and traditional childbirth practices and delivery positions “backward" and "unsanitary" as compared to clinical deliveries, hence forgoing the traditional practices for the modern ones (Fraser, 1998; Shiferaw et al., 2013; see chapter three and four). More importantly, transnational feminist scholars have emphasized the need to pay attention to global complexities and local specificities (Browner & Sargent, 2011; Mohanty, 2003). In my research it was crucial to look at global population and reproductive health frameworks and policies along with the local desires, needs and experiences of Amhara and Oromo women.

Transnational feminist theory has been effective in examining transnational processes such as globalization and the globalized economy and its gendered impacts (Hawkesworth, 2006; Kozol & Hesford, 2005). This theoretical framework has been valuable in examining the impacts of the globalized economy on the Ethiopian health policy and finance and the local lives of women in Oromia and Amhara regions. In addition, a transnational feminist view has allowed me to take care not to represent

Amhara and Oromo women as mere victims and the nation as a whole as a passive aid-recipient. While revealing the difficult circumstances in which women reside, I also try to demonstrate their resistance and agency.

Other significant epistemological and methodological frameworks that inform my research are African indigenous and feminist methodologies. These frameworks are useful in examining the localized gender and reproductive health ideologies and experiences of women in Ethiopia. Indigenous methodologies are worldviews and strategies that value and center the knowledge of indigenous, marginalized and colonized people (Chilisa, 2012; Kovach, 2009; Mertens et.al, 2013; Smith, 2012). These knowledge systems counter Euro-western knowledge and perspectives that have been detrimental and oppressive to indigenous lives and cultures. Western thought and academe have for many years regarded African indigenous knowledge systems as superstition or ignorance and African people as primitives living in a "dark continent" (Zegeye & Vambe, 2006). Many African and international reproductive researchers continue to use these dominant western perspectives often misrepresenting the experiences of African women. In this research, I particularly have employed transnational and African indigenous perspectives to challenge the ways in which development and modernization narratives are considered superior to the knowledge of women and their communities and how these narratives influence and shape maternal health services and reproductive health knowledge in Ethiopia. My feminist approach to understand social conditions distinguishes the study from previously conducted biomedical and social science studies. The feminist and indigenous methodology I employ allows me to value and center the perspectives and knowledge of women and

their communities. For instance, my inquiries about the context of marriage, particularly early marriage, polygamy, education/knowledge and the process of childbirth, particularly traditional birth practices, do not begin with the popular development intervention assumptions that these cultures and social interactions of the community are "dangerous/harmful or backward" or that the solution is to eradicate them completely. Instead, I began my inquiry with the view that women and their communities have a better understanding of these social conditions and made an effort to understand the complex ways women and their communities experience and engage in these social interactions. As a result, I here present some alternative perspectives from what has already been established in national and international development and health policies and interventions about these underlying social causes that may be useful for future program design.

Central to African indigenous perspectives and the study of gender and maternal health is therefore, “the deconstruction of western thoughts, categories, analysis and knowledge production about Africa, Africans, African women [and men] as a vital step toward producing knowledge that expresses the lived experiences of women” in Africa (Chilisa, 2012, p.260). African indigenous perspectives value lived experiences and critique western forms of knowledge acquisition and preservation (Wane, 2008). Indigenous methodologies and specifically African indigenous views hold that knowledge is not individually owned but shared and this knowledge is partial, situated and context specific, requiring researchers to be self-reflexive about their authority over knowledge, their generalizations and values, and to critically examine power dynamics in the context of knowledge production (Kovach, 2009; Mertens et.al, 2013).

The African indigenous world view of wholeness and community where the person becomes human and whole in relation to and amidst others is another crucial aspect to examine when studying women's reproductive and gender relations (Owusu-Ansah & Mji, 2013). These concepts of identity challenge western, individualistic conceptualizations of women outside of their social and collective identity in the African context. Collective knowledge and collective sense of responsibility and interdependence for survival inform women's reality in many African communities (Owusu-Ansah & Mji. 2013). Many family planning interventions have failed in African nations because these programs targeted women individually (Sandisky, 2011). In this study, I have employed this African indigenous worldview to challenge international and local reproductive health services that have targeted only women in their programs without due emphasis on their social interactions with their partners and families.

African feminist ideologies that pay attention to the unique experiences of African women are significant in the study of maternal health in Ethiopia. Nnaemeka (2004) argues that African feminisms as practiced in the African context are not constructed based on antagonizing and binary gender relations of the sexes widely adopted and universalized by mainstream western feminism but rather on ideas of gender complementarity. Nnaemeka (2004) discusses the theory of Nego-feminism where negotiation and compromise rooted in the indigenous notions of interdependence take place between men and women in the process of resisting or complying with patriarchal systems. The conceptualization of gender on the basis of complementarity and interdependence was specifically significant in the Oromo community as I began to understand their perspectives on polygamy (see chapter four). Similar to the ideas of

intersectionality in the US, African feminists argue that the salience of gender as a category of analysis is dependent upon the social and historical context (Oyeumi, 1997). African feminisms also challenge the universalization of the nuclear family where the role of the extended family in the African context is not considered (Oyeumi, 2000). I have engaged women as well as men and the views of purposefully selected community members such as elders, traditional birth attendants (TBAs), priests and young men and women recognizing their role in women's lives and in the experiences of maternal health. Hence this research presents a counter-narrative to development programs and maternal health research that universalize gendered experiences and view Ethiopian women as only individuals and not part of the collective community in which they reside.

Bearing in mind that the constructions of masculinity are varied, my analysis of men's role in maternal health paid attention to the diverse experiences of men based on class, ethnicity, and cultural variations in the two regions. In line with Connell & Messerschmidt's (2005) portrayals of masculinities as multiple and changing, the study regards men's social constructions, attitudes and perceptions in society and particularly on maternal health issues as dynamic and fluid (Connell & Messerschmidt, 2005). Dominant narratives in reproductive health have often presented men, particularly third world men as hyper-masculine, violent and hegemonic in relation to women and in the discussion of reproductive health behaviors (Cornwall et al., 2011; Plantin et al., 2011; Uchendu, 2008). Consequently, men are often imagined as the problem and not part of the maternal health solution. While these types of masculinities do in fact exist in the Amhara and Oromia context, I argue that the socio-historical setting in which these masculinities are constructed often is not examined (Cornwall et al., 2011; Uchendu,

2008). Moreover, narratives of alternative masculinities about men who are non-dominant and supportive of women in childbearing and rearing processes are not acknowledged (Plantin et. al, 2011). Hence, I begin the study with the assumption that multiple masculinities and alternatives to the hegemonic construction of masculinity exist in Amhara and Oromia. Thus, I have made an effort to document these alternative narratives as possible entry points for reproductive and maternal health interventions.

Feminist Research Ethics and Self-Reflection

Feminist research ethics informs us about the power relations between the researcher and the researched, and I have strived to pay due attention to the power dynamics that exist between the research participants and myself (Chilisa, 2012; Jaggar, 2008; Smith, 2012). In this research, while recognizing difference, I also emphasized connectedness and relationship-building, which is central to African indigenous perspectives (Chilisa, 2012). “The connections that indigenous scholars have with those around them should form part of the social history and should inform how they see the world and how they relate with the researched” (Chilisa, 2012, p.3). Hence the initial relationships I built with women and men in these communities have been crucial for the research process.

As a self-reflexive process, Patricia Hill Collins' (1986) concept of the "outsider-within status" describes my own social position as a researcher. As an Ethiopian woman with a mixed Amhara and Southern ethnic identity, I can explain some cultural experiences as an insider. At the same time, being an educated, non-Oromo, young woman from an urban area who did not have a child at the time created my outsider

identity in the communities I studied. Consequently, I had some encounters related to gender, age, language (specifically in the Oromo community), and other cultural practices that created room for learning and self-reflexivity. Mediating the tensions that arose as a result of my varied social positions and research goals was significant as part of my feminist epistemological commitment. The following were some of the encounters and challenges I had when conducting my fieldwork.

Because of my Amhara identity and the fact that I speak the native language, Amhara participants simply assumed that I already knew what they know or what they were going to discuss with me. A woman in Andenet Kebele in Amhara had asked me the following question when I asked her about cultural perspectives on marriage and the traditional childbirth process: "How come you ask me these questions, and how come you don't know these things? Have you not lived here [in the country]?" I had to explain the significance of hearing her views and perspectives and how her knowledge is valuable to my study. In addition, some participants initially assumed that I came from the government health office because of my inquiries about maternal health. I had to explain and distance myself from the government health offices because I was not a representative and was aware of the power dynamics and tension this would create between the research participants and myself.

Another outsider-within experience was about deconstructing and decolonizing views held about indigenous and traditional knowledge in the community. For instance, when I inquired about formal and informal knowledge and education, the majority of the respondents would immediately refer to formal education and inform me that they have no knowledge because they did not go to school. As an insider and outsider, I am aware

of the indigenous knowledge that participants do not regard as knowledge. Together we unearthed and recognized the knowledge and practices that they have acquired generationally from ancestors such as farming practices and health remedies that they primarily use to sustain their day-to-day lives. This created a moment of connectedness between the research participants and myself; it was a moment of collective, re-learning and valuing what has been subjugated and overshadowed by western, modernized, education and development narratives. Similar narratives about how communities have internalized and valued western education over their indigenous knowledge have been documented elsewhere in Africa. Wane et al. (2011) notes how rural Kenyan parents value colonial education as a result of their socio-economic status and strive to send their children school (Wane et al., 2011).

As a young female researcher coming from the urban setting, I encountered some challenges in both the Amhara and Oromia regions. The traditions and cultural settings do not provide the grounds for women researchers to solicit responses from men. The male Oromiffa translator and research assistant interviewed male participants while I recorded their responses. The men felt more comfortable to discuss their views when they assumed he was in charge. Such a form of research negotiation in a patriarchal context is similar to what Nnaemeka (2004) refers to as Nego-feminism and it has allowed me to mitigate the concerns I had of not being taken seriously both because of my age and gender. The communities I visited often regard pregnancy and childbirth as a woman's domain. The involvement of a male research assistant made it easy for male community members to take part in the research topic they often regard as a woman’s domain.

Underlying Assumptions and Feminist Perspectives on Maternal Health and Motherhood

Past and current dominant discourses of maternal and reproductive health have some underlying assumptions worth examining. States, medical establishments and international organizations have employed these underlying assumptions to design and organize maternal health programs and policies. The first assumption is that childbirth is a medical process that needs medical attention by medical professionals in a hospital setting (Conrad, 2007; Glenn et al., 1994; Prosen, 2014). In other words, this assumption refers to the medicalization of childbirth. "Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders." (Conrad, 2007, p.4). Before the 19th century, childbirth in western societies was considered a natural phenomenon and home delivery was prevalent in many areas. With multiple factors contributing to maternal and prenatal deaths and with the process of modernization and the industrial revolution in the West, the medical and scientific establishments decided to intervene and label the natural childbirth process as risky and pathological (Johnson, 2014; Prosen, 2014).

Categorization of childbirth as a risky, pathological process allowed medical institutions to control and regulate the event and women's bodies in an institutional setting (Prosen, 2014). The literature on the medicalization of childbirth and the biophysical experiences of women demonstrate that women’s life experiences have been pathologized and medicalized more than those of men (Conrad, 2007). Male and female bodies have been constructed through science as naturally different and the white European middle-class, heterosexual men's and women's bodies have been used as the standard for measuring normality of other bodies everywhere. Women's bodies have been subject to more medical

scrutiny, as they have been deemed "inferior" to those of men and because of the visibility of their psychological processes and their social subordination. The medical institution thus has extended society's pursuit to control and subjugate women's bodies (Conrad, 2007; Glenn et al., 1994; Woliver, 2002). Ann Oakley (cited in Glenn et al., 1994) describes the medicalization of the birthing process as one that has deemed women giving birth as "unfit" to make rational decisions or to accurately report symptoms when in stress (Glenn et al., 1994). Delivery in a hospital where basic and emergency obstetric care is available has brought about undeniable benefits for saving pregnant women's lives through reproductive technologies which have saved the lives of many women who can access it. However, the power exercised by medical institutions on women with different social backgrounds and their bodies, and the suppression of their reproductive knowledge have been detrimental (Bridges, 2011; Ginsburg & Rapp, 1991).

The knowledge-power relationship in the medicalization discourses also requires examination. Feminists argue that when childbirth was medicalized, women’s traditional reproductive health knowledge and childbirth practices were devalued (Roberts, 1997; Shiva, 1988/2010). Midwives were replaced by male physicians and medical technologies despite the fact that there was evidence that physicians were having even worse success rates of child delivery as compared to traditional midwives who were excluded from the practice at the time (Johnson, 2014; Prosen, 2014; Roberts, 1997). African American midwives in the US South, for instance, were replaced by white public health practitioners (Fraser, 1998). African traditional birthing and child rearing techniques including traditional birth spacing methods were rendered “backward” and “dangerous” in the context of colonization and modernization (Hartmann, 1995; Thomas, 2003). Similarly, as

we will see in chapter three, current reproductive health initiatives in many African countries including Ethiopia have virtually replaced traditional birth attendants in rural villages with health extension workers (HEWs)[4] and scientific midwives (Chintu & Susu, 1994; Morsy, 1995; Roro et al., 2014; Shieferaw et. al, 2012).

Despite the continued insistence on the medicalization of childbirth in the Global South, we are currently witnessing its radical transformation in some western settings, where natural childbirth processes, birthing rooms and traditional practices are encouraged among upper and middle-class women (Conrad, 2007; Dick-Read et al., 1984; Johnson, 2014). The commercialization and commodification of traditional childbearing and rearing practices of women in the Global South as the "new healthy thing" in the West have been commonplace for years (Ginsburg & Rapp, 1995; Johonson, 2014). Ex-Peace Corps volunteers who became millionaires in the 1960s and 70s selling “natural” methods of childcare learned in Africa is an example (Ginsburg & Rapp, 1995). The natural childbirth process at home in now a commercialized process that only people with resources can afford in the West (Johnson, 2014).

Another narrative prevalent in maternal health discourses and programs is that **“**prevention is better than cure." As mentioned earlier, population institutions and governments have promoted family planning programs as a preventive and cost-effective mechanism for maternal health services (Hartmann, 1995). Preventive measures such as the provision of contraceptives, antenatal and prenatal checkups, better nutrition and

[4] HEWs are young women, high school graduates selected from the community (2 from each Kebele) that provide health information, education and primary health care services. They are primarily health care providers with minimal training and are the driving forces of the health extension program at the community. See chapter three for further reference.

improvement in pre-existing health conditions before and during pregnancy have been significant in preventing maternal health complications. However, many feminist scholars have argued that the preventive measures promoted by most maternal and reproductive health services mainly focus on contraceptive provision motivated by coercive population control frameworks that limit the fertility of third world women and women of color in the West (Hartmann, 1995; Takeshita, 2012). Nations like India and China are examples of contraceptive targets set in national health policies and the sterilization of a significant number of married women who have stated in the national demographic and health surveys that they wanted more children (Hartmann, 1995; Takeshita, 2012). There are also nations like Ethiopia that outline subtle but equally effective population control narratives outlined in their policies in (see chapter three).

Another underlying assumption is related to ideas of motherhood and autonomy. Mothering more than any other gender construction has been tied to women's biological abilities to bear children, universalized, deemed natural and unchanging (Glenn et al., 1994; Rothman, 2000). Glenn et al. (1994) define mothering as a historically and culturally variable relationship "in which one individual nurtures and cares for another. Mothering occurs within specific social contexts that vary in terms of maternal and cultural resources and constraints" (p.3). This is a comprehensive definition that moves beyond the biological aspect of childbearing to include various forms of mothering in different social contexts. However, to date, a universalizing assumption about motherhood still prevails in many societies (both western and non-western). The belief that all "normal" women desire children and those who reject motherhood are rejecting womanhood is further reinforced by science (Glenn et al., 1994). Amhara and Oromo women's gendered identity is similarly

related to notions of motherhood (see chapter four). Another myth is the 1960s child developmental psychology of maternal bonding, where the child/mother bond is depicted as a healthy (and possibly the only) way to build other social relationships. Feminists have debunked both myths as social constructions that serve oppressive patriarchal ideologies (Rothman, 2000). However, as Ginsburg and Rapp (1995) have explained, such social constructions are also internalized by women and shape their reproductive and maternal health outcomes.

The construction of gender roles in childbearing and rearing that has been universalized based on white middle-class women's experiences is another assumption of motherhood worth examining. The idea of women (biological mothers) as the exclusive caretakers of children and the individualistic context in which a woman carries out her reproductive roles in a nuclear family setting have been projected on to the mothering experiences of other women in maternal health programs across race, class and sociocultural contexts (Glenn et al., 1994; Rothman, 2000). Women of color, queer women and third world women challenged these notions of motherhood. The socio-historical contexts in which women of color are valued not as mothers but as cheap laborers for the sustenance of white women's families present a counter-narrative to the presumed universality of mothering experiences. "Shared mothering" within their communities and a constant shift between the public and private are realities for many women of color (Glenn et al., 1994, p.6). As mentioned in the previous section, African women's role within the family and their interconnected existence with men and other women have challenged this individualist construction of motherhood (Oyeumi, 2000). Such constructions do not take form only in discourse but rather in social interactions, identities and social institutions

that impact women's health outcomes. Maternal health research and development initiatives that study gender constructions in Africa, for instance, have mainly focused on women as individuals and their decision-making authority within a nuclear family setting (Adjiwanou & LeGrand, 2014). Adjiwanou LeGrand (2014) argue that limiting the analysis of gender constructions to the individual or household level will only provide a partial picture of gender and maternal health issues. As stated earlier and as I will further discuss in chapter five, women in many rural settings often do not make decisions on their own; often husbands, in-laws and other family members take part in the decision-making process (Gurmu & Dejene, 2012; see also chapter five).

Study Design

Study Area

Ethiopia is found in the northeastern part of Africa. It is the 10th largest nation in Africa with an area of 1,104,300 square kilometers. It is the second most populous country in sub-Saharan Africa with an estimated population close to 96 million, and 65 percent of its current population is below the age of 24 (MOFED, 2009)[5]. With the downfall of the Derg-People's Democratic Republic of Ethiopia- a Socialist regime that had stayed in power for over 17 years (1974-1991), the current ruling party EPRDF (Ethiopian Peoples' Revolutionary Democratic Front) established a federal government. EPRDF has been in power for the past 26 years. The nation now has nine regional states based on ethnic groups representing different nations and nationalities namely Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella, Tigray and Harari, and two city administrations

[5] *CIA: The World Fact book*. Retrieved from *https://www.cia.gov/library/publications/the-world-factbook/geos/et.html*

(Addis Ababa and Dire Dawa) (See Appendix B for regional maps). Oromia and Amhara are the 1st (34.4%) and 2nd (27%) largest regions of Ethiopia respectively in terms of population and geographic location.[6]

The current regime adopted a new constitution in 1994 and developed new economic and social sector policies. The constitution has improved relative to the previous constitution in terms of women's rights. It clearly stipulates the rights of women under Article 34 and 35, which were not previously discussed. It condemns violence against women and promotes equal opportunities in education, health, economy and other sectors of the nation (Federal Democratic Republic of Ethiopia [FDRE], 1994). In addition, a state ministry (the Ministry of Women's Affairs) and regional offices have been established to address gender issues.

Among the major changes that have taken place during the political transition over the past 26 years is the economic and social sector reform of the government as a poverty reduction strategy and the privatization of formerly government-owned or nationalized sectors. With the exception of telecommunications, financial and insurance services, all other services and sectors including air and land transport and retail have been either fully or partially privatized (Ministry of Finance and Economic Development of Ethiopia [MOFED], 2010). Ethiopia's economy is largely dependent on agriculture and the service sector, which account for 46.6% and 45% of the gross domestic product (GDP) respectively.[7] Agriculture is the leading sector accounting for 85% of total employment, the supply of food for domestic consumption, manufacturing and export

[6] Ibid.
The central statistical agency of Ethiopia that has conducted the population census in 2007 also states this fact. However, CIA world fact book provides a recent population estimate.
[7] Ethiopian Government Portal (2012). Retrieved from http://www.ethiopia.gov.et/web/Pages/Economy

commodities producing the highest percentage of foreign exchange earnings for the nation.[8] Recently the economy of Ethiopia has been claimed to be among the fastest growing economies with a double-digit growth of 11-12%. (MOFED, 2010). However, with the lack of access to basic services, fewer job opportunities, food scarcity, environmental degradation, global economic processes that deprive the population of land and resources, and various health, education and infrastructure problems that have resulted in severe poverty among the growing population, Ethiopia remains one of the poorest countries in the world (CSA, 2013).

Health and education are among the sectors that government is currently reforming as part of the poverty reduction strategy and the growth and transformation plan of the government. (MOFED, 2010). The government predominantly runs the health and education coverage program and they are partly privatized. In the past ten years, health service user fees and educational cost sharing schemes have been established as part of the health and education financing reforms (FMOH, 2006). These privatization strategies are presumed to reduce loans and debts from foreign agencies. I argue in the next chapter that these strategies are mainly promoted by international financial institutions like the World Bank and the International Monetary Fund and other funding agencies as part of the "economic development" strategies for poor nations (Shiva, 1988/2010). These strategies have a huge impact on maternal health outcomes of third-world nations (Shiva, 1988/2010). The development perspective is evident in how most of the government documents narrate these reforms in the context of growth, progress and development. It is also important to note here that health and education were free to

[8] Ibid

the population prior to the privatization and reform of these social sectors. Chapter two and three thoroughly discuss the Ethiopian health system its historical development and relevant structures, policies, plans and implementation strategies related to maternal health.

As discussed above in this research I explore maternal health issues in Ethiopia in two of the largest regions of the nation namely Oromia and Amhara, in Seden Sodo and Mecha Woredas (district) and more specifically in Mudena Ibayyuu and Andenet Kebele in each of the Woredas. I assess how gender, age, religion, ethnicity, class, location and other factors may influence women's health outcomes of pregnancy and childbirth. Oromia and Amhara are two of the largest regions in terms of population, geographic location, and ethnic representation. Even though it is not feasible to address other ethnicities and birth cultures of the nation in this study, the selection of these regions is significant in terms of capturing some of the ethnic and cultural variations among women in the nation.

Seden Sodo and Mecha Woreda

My selection of specific districts and Kebeles was based on regional and Woreda statistics on population, remoteness from the main town and roads and inaccessibility of the health facilities for Kebele residents. This selection is primarily a result of other studies and surveys confirming that access to health services, roads and nearest town has a lot to do with maternal health challenges that women face in their communities. Maternal mortality rates tend to be higher in remote rural places where infrastructure and basic and emergency health services are difficult to access. Therefore, this study specifically focuses on the experiences of women and men in Mudena Ibayyuu and

Andenet Kebeles. The Kebeles I have selected from both regions (Mudena Ibayyuu and Andenet) are Kebeles that are relatively remote with difficult terrain for health access but were also logistically feasible with the minimum amount of financial resources I had to conduct this research. Particularly Andenet Kebele and the remote part of Mudena Ibbayyuu Kebele had rivers, mountains and roads that made access to the nearest towns where the health facilities are located difficult for the population. In addition, according to the Woreda health bureaus, these Woredas and Kebeles were the ones that were performing poorly in terms of maternal health services.

Mecha is one of the largest Woredas in the Amhara region and it is part of the West Gojam Zone[9] with 40 Kebeles and a population of 370,000[10]. Nearly half of the population are women (49.4 %). Amharic is the local language and the majority of the residents of the Woreda are Orthodox Christians (98.9%) while 1.1% are Muslim (CSA, 2007). Andenet Kebele is one of the Kebeles of Mecha Woreda and is about 35 kilometers (22 miles) away from the main road to the town of Merawi. Participants have often mentioned that there is no transportation that goes from the Kebele to the main town and that it takes on average about 4-6 hours on foot. There are three small villages (Gote) within Andenet Kebele called Lay Kolella, Tach Kolella and Efesa. Participants have informed me that most of the maternal mortality incidences in the Kebele are from Efesa which is farthest from the other two small villages and it is the one with the most difficult terrain. I have made an effort to include participants from these three small villages both in the interviews and focus group discussions.

[9] Subdivisions of the regional states of Ethiopia
[10] The population statistics are taken from Mecha and Seden Sodo Woreda Health Bureaus.

Seden Sodo Woreda, formerly known as Kokir, is found in South West Shoa Zone of the Oromia region with a population of 170,000. Similar to Mecha Woreda, nearly half of the population are women. The three largest ethnic groups here are Oromo, Silte and Soddo Gurages. The specific Kebele, Mudena Ibayyuu, is mostly inhabited by the Oromo ethnic group. According to the 2007 census of the Central Statistical Agency of Ethiopia, the majority of the inhabitants (81%) are Orthodox Christians while the rest of the population are Muslims (17%) and Protestants (2%) (CSA, 2007). There are three small villages, namely Siibaa, Waayu, Harbu Ibayyuu. It is about 20 kilometers from the remote areas of the Kebele to the nearest Woreda health center in the main town of Harbu Chulule or to another town called Tulu Bolo which is also 20 kilometers once you have reached the main gravel road. These distances are from the main road of the Kebele to the nearest town but there is an average one and a half hours to three hours walk from the small villages of Waayu and Harbu Ibayyuu to the main gravel road that is not included in these distance estimates. In this work I discuss findings in terms of the overall region or these specific Kebeles.

Methods and Data Collection

In this research, I have used qualitative research approaches for data collection, analysis, and write-up. I utilized a methodological triangulation approach to benefit from the use of multiple sources and methods to study the experiences of women and men, looking for convergent evidence from different sources such as interviews, focus group discussions and personal observations (Marshall & Rossman, 2006). These combinations of methods and data sources were necessary to provide a comprehensive view of maternal health challenges from the views and experiences of various groups in the

community. Interviews and focus group discussions were selected because in the case of women's lived experiences, longer face-to-face interaction better serves the purpose of understanding participants' thoughts, feelings, beliefs and values as they are being expressed (Marshall & Rossman, 2006). Moreover, open-ended interview questions provided room to probe for further clarification and to gain deeper perspectives about the participants' experiences.

Once I had an IRB approval from ASU, I travelled to Ethiopia to conduct my fieldwork. Traveling to Ethiopia, particularly to the two rural regions and districts of Ethiopia, posed logistical and financial challenges.[11] The study proposal went through another process of ethical research review at the Federal and Regional Health Bureaus of Ethiopia. Although the process was quite bureaucratic and arduous, I appreciated the research ethical committee's zeal to protect communities from harm.[12] As mentioned earlier, I traveled with one male research assistant and translator in both Kebeles bearing in mind the cultural connotation of a young woman coming to ask questions. This was mainly significant for men participants.

I began my field work using my previous research networks in these regions to contact federal and regional health offices who wrote letters of cooperation that I presented to the Woreda health bureau and Kebele administrations. Kebele administrations, in turn, introduced me to health extension workers and road guides who

[11] Finding transportation that is affordable to and from the Kebeles was difficult. While we were fortunate to find a ride from the main towns, like our research participants we walked from one Gote to another on foot on average, from one and half hour to three hours. We crossed rivers and trekked hills and the fact that it was a rainy season made the journey much more difficult. One can imagine the difficulty pregnant women face traveling these roads on a daily basis.

[12] The regional health bureaus explained that they had encountered various international, NGO and local researchers going to the communities and conducting studies that were harmful to the communities.

took us from one household to the next. Road guides and health extension workers were crucial in helping me identify households. However, I had to deliberately distance myself from the Kebele appointed road guides and health extension workers when conducting my interviews since some research participants might assume that I came from the health ministry or that I was a health professional. Even with great effort as you will see in chapter three, initially, some participants were not comfortable to be interviewed until I explained that my research is not connected to government health programs. To avoid such misunderstandings, I also used women's informal networks to recruit other women and I would ask the road guide to take me where the previous interviewee had directed me.

With the permission of the women, almost all interviews with women mostly took place in their homes, as they were conducting their daily chores of cooking, baking injera (the staple bread), farming, cattle herding and looking after their children so as not to take additional time from their daily activities. Similar to what Collins (2000) explains in intersectional research and knowledge production, interviewing women in their "safe space" and meeting them where they are to document their perspectives is especially important in the feminist research methodologies I have employed. In the case of Oromia, I made an effort to interview women with female translators. Interviews with men were mostly conducted outside of the Kebele administration offices when they were coming for their own business. Interviewing men during farming days was not possible due to the nature of their work.

Language barrier was a limitation in the Oromia region. However, Oromo women and others from other ethnic groups have been left out of various small scale and national

research projects on the grounds of language barriers. The Amharic language is the dominant national language used to conduct research and many Amharic-speaking researchers tend to gravitate towards studying the regions where Amharic is the primary language. I attempted to capture the experiences of Oromo women and their communities even with the challenges and limitations of the language barriers and the information that might be lost in translation. I conducted the interviews in Oromiffa with the help of a fluent and community-approved translator; I then transcribed the translations into English. In addition, I made a conscious effort to learn some salutations and acknowledgments, consent requests and other research relevant words in Oromiffa, so that I was able to create a connection with the research participants.

I completed primary data collection between the months of June and August 2015. Each interview took from one to one a half hour and the focus group discussion lasted from one and half hours to two hours. For secondary data, I have conducted a literature review analyzing global and local policy documents on reproductive health and development, other texts on the socio-cultural contexts of maternal health and masculinities.

Research Participants

Overall this study involved 46 research participants and six key informants making a total of 52 individuals. I selected research participants through purposive and snowball sampling and using women's and men's informal networks. I conducted the sampling based on the location of household (Village-Gote), age and marital status. I obtained this demographic information from the health extension workers who frequently visit each household for the government health activities. In addition, I also employed

snowball sampling using women's and men's informal networks to find research participants. Some interview participants directed me to a friend in the other villages. Interview research participants included a total of 30 women (15 from each region) who were between the ages of 18 and 40. As mentioned above one of the selection criteria was that women were within the conventional definition of reproductive age (15-49). This was significant to capture the most recent experiences of childbirth. However, I also included women older than 49 in the focus group discussions in order to gain an understanding of long-standing impacts and socio-cultural issues related to maternal health that women can explain from previous experiences. All participants were married.

I selected ten married men (5 from each region) for the interviews. In addition to the individual interviews, I conducted two focus group discussions with a total of 16 individuals (8 from each region) comprised of various members of the community who were not included in the individual interviews. I engaged community members such as elders, traditional birth attendants (TBAs), priests and young men and women. Others that I interviewed include a total of 6 government officials from the federal (1), district health bureau (2) and health extension workers from each Kebele (2) and a nurse from the Woreda health center (1).

Data Analysis

Data analysis for this research included the analysis of both primary and secondary data. I have conducted a policy review and textual analysis of government and international policy documents, small-scale studies and other texts relevant to examining global and local development and reproductive health policies, politics and how these factors shape local maternal health policies and implementation.

To analyze the primary data collected from the regions, I transcribed interviews from Amharic to English with the help of research assistants. The responses were coded and categorized based on general and new emerging themes. Analysis and discussion of key findings are, therefore, based on the overall and new emerging themes, research objectives and key questions I have set out to address. Consequently, the themes in these chapters are a result of both the primary and secondary data analysis of global and local policies and the social determinants of maternal health.

In the following two chapters (chapter two and three), I explore how local maternal health issues relate to larger global economic processes and how global and local development and reproductive health politics inform and influence maternal health service provision at the local level. Accordingly, in chapter two, I provide a brief review of the historical trajectories of development and how a global development agenda has come to influence health systems, particularly the Ethiopian health system. I also specifically address how global economic development programs that are market-oriented influence the availability of comprehensive, basic and emergency obstetric and reproductive health services (Grown et al., 2006; Petchesky, 2003). I argue that despite the sponsorship of most of the health initiatives by western-dominated global financial institutions, the development frameworks are the platforms that third world nations like Ethiopia utilize to urge for and establish a more comprehensive and community-centered reproductive and maternal health programs. With minimal resources and the complicated conditions of maternal health service provision, poor third world nations like Ethiopia make an effort to provide universal health care and cost-free maternal health services (FMOH, 2015a). I contend that the push and pull between compliance with global

economic and development frameworks and third world nations' efforts to find some leeway to make policy priority statements in these global interactions is what is often missing in feminist and international development analysis and critique. Often third world nations are portrayed as passive aid recipients that do not seem to challenge these global development conditions.

In chapter three I specifically discuss maternal health policies and implementations in Ethiopia and the national paradox between policies' compliance with global reproductive and economic development agenda and the attempt to provide comprehensive reproductive health services. I also address development and modernization narratives in the implementation strategies that do not take into account some socio-cultural factors and the indigenous health practices of women and their communities. Chapter four discusses the social determinants of maternal health in Ethiopia looking at how age, gender, education, income, fertility, family planning use and other factors shape women's maternal health experiences. I also discuss the process of childbirth for most women and explore women's perceptions of these practices as possible directions for future interventions.

In chapter five I discuss the involvement of men in maternal health and the extent to which the government has incorporated ICPD's reproductive health paradigm that stresses the need to involve men in reproductive health service provision both for themselves and their partners. The majority of reproductive and development narratives in policies and implementation strategies both globally and at the national level only address hegemonic ideas of masculinity related to reproductive health. Analysis of men's masculinities in relation to women's social status, autonomy and decision-making in

health without due emphasis to other social identity markers and structures such as class, location, global economic conditions impacting local subsistence livelihood, socio-cultural and political factors can be misleading. The findings both from this study and my previous research reveal the presence of varied forms of masculinities in addition to the usually narrated hegemonic, patriarchal and dominant roles of men in various reproductive health research texts. I argue that these alternative forms of masculinities can serve as entry points for bringing about social and behavioral change. They also can be employed to create community and government based initiatives for maternal health emergencies that are legitimized and supported by men and women in the community. In chapter six, I conclude with the way forward and possible alternative perspectives to improve maternal health experiences of women.

CHAPTER TWO

GLOBAL AND LOCAL DEVELOPMENT AND REPRODUCTIVE HEALTH DISCOURSES AND THE ETHIOPIAN HEALTH POLICY

Prior to discussing Ethiopia's current health policy and the sector-wide development approach it employs, I introduce the concept of global development and how it has evolved in international fora. The health service of Ethiopia and the Health Service Development Program (HSDP) is an integral part of the country's broader development agenda (i.e. Ethiopia's Growth and Transformation Plan). As such, it is guided and impacted by the nation's overall development policy framework. In the same manner, Ethiopia's overall development efforts take place within the global environment of complex bilateral and multilateral relations, various development frameworks, initiatives, campaigns and movements. These various aspects of the global environment may exert positive or adverse influences or impacts on national health efforts. The negative impacts may come in the form of political and economic pressures, an imposition of exogenous policies, ideas or aid conditions that undermine local initiatives, indigenous knowledge and practices. The positive impacts may result in policies that promote health and economic development for all, gender sensitive approaches and better funding for health services and policies that value community-based health initiatives. Ethiopia's health system, and hence its maternal and reproductive health programs, are no exception in terms of exposure to such positive or negative impacts.

In order to address modern health challenges as a whole and maternal health in particular in non-western nations like Ethiopia, there is a need to understand how

development discourses, western scientific narratives and health systems have influenced the policies of these nations over the years in the context of colonial and imperial legacies and other recent economic and historical factors. It is useful to trace how these discourses have been maintained and in some instances resisted in the varied historical contexts and at multiple levels of health services provision to understand how specific national maternal health policies have been designed and how these policies impact the lives and reproductive experiences of women. This chapter is therefore primarily a literature review and policy analysis of global development and maternal health discourses and the formation of early and current Ethiopian health policies in light of the global development and reproductive discourses and frameworks.

Global Development Discourse

Development is primarily a western concept that has ancient roots going back to the philosophy of western knowledge and progress (Rist, 2014). The term 'development' has been widely used in western scientific discourse as early as the 17th century in the natural sciences and it was later presented as a "naturally unfolding universal social process" where societies gradually evolve into modern nation states (Cooper & Packard, 1997; Rist, 2014, p 42). Rist (2014) in *The History of Development* notes that at the heart of western social development thought is the totalizing narrative that development is the same across societies [meaning it should resemble that of Euro-American social development] and that all nations must go the same route of development. This narrative also asserts that non-western nations are far behind the development of western society as a result of "the greater size of its production, the dominant role that reason plays within it, and the scale of its scientific and technological discoveries" (Rist, 2014, p.56; Parpart et

al., 2014). This idea has helped to naturalize the process of social development and western superiority on the basis of “natural” social evolution and the scientific knowledge and resources they have amassed over the years.

Western theories claiming to be scientific have had a significant role in establishing these "truths" about social and economic development globally, creating the binary classifications of nations, peoples and geopolitical spaces as either "civilized" or "uncivilized", third world or first world or the more resuscitated classification of developed/underdeveloped (developing) (Mead & Walker, 1991; Shiva, 1988/2010). These binaries have served various purposes over the centuries including colonization, imperialism, capitalism and establishing the cultural and intellectual superiority of the West onver others (Ibid). Specifically linked to reproduction, 18th-century demographers and economists like Thomas Malthus and his proponents for instance linked economic progress and social development in Europe to the decline of the population and the industrialization and modernization process underway (Hartmann, 1995; Koblitz, 2014). Conversely, demographers and environmentalists linked famine, poverty, environmental problems and the absence of wealth and resources to overpopulation in Asia and Africa and the lack of knowledge and civilization among their subjects (Lee & Feng, 2012). Hence, scientists and demographers in the West attributed the population dynamics to the process of modernization and industrialization of the time and the supposed ability of western subjects to regulate their fertility and posited the lack or absence of such conditions in non-western nations.

Purportedly superior health and the wealth of the West are often presumed to be ageless truths which have no connection to the poverty and ill health of poor non-western

nations (Gish, 2004). However, the health and wealth gap of today did not occur in a vacuum but within the historical context of territorial expansion, conquest, colonialism and imperialism. Western territorial expansion and colonization in the 19th and 20th centuries were justified with ideas of social evolution and development (Cooper& Packard, 1997; Rist, 2014). Cooper and Packard (1997) for instance explain how colonial governments contended that their modernizing initiatives would make their colonies more productive. Colonial governments sent various experts to "improve" or "develop" agriculture, education and health in their colonies, making colonialism seem like a philanthropic project (Cooper & Packard, 1997, Rist 2014).

Contrary to what colonial governments claimed, colonization was a major factor in the deterioration of health conditions in the colonies. In the *Legacy of Colonial Medicine* Gish (2004) explains how the establishment and promotion of modern medicine and an "inadequate top-heavy" health system[13] set up by colonial governments were among the major obstructions that had a lasting impact on the health of populations in the colonies in addition to the mass depletion and looting of their material resources and the introduction of new diseases and disease environments in the colonies. Some of the colonial health systems are still functional in many third world countries today. The erasure of community-based structures and knowledge in health, agriculture and

[13] Gish 2004 notes that "Typically "modern" medicine in the colonies- whether in Africa, the Caribbean, Asia and Latin America - comprised three major components: the urban hospital, the rural dispensary which was often related to the Christian Church and the hygiene or public health system." (p.21). In most cases, the populations in the colonies were considered sub-human and were not considered worthy of good health. Populations in the colonies were afforded health benefits only when they serve the interests of the colonizers.

education contributed to the exclusion and ill-health of the masses in colonized nations (Cooper& Packard, 1997, Gish 2004).

Modern concepts of health and health systems including the medicalization of childbirth and theories about population growth are all parts of global development and modernization discourses that are accepted as "facts." Examining these taken for granted "facts" will allow us to see the challenges and gaps created as a result of the modern day applications of such development ideas, policies, and programs particularly in non-western nations like Ethiopia.

Global Market-Oriented Development Post Second World War and Its Impact on Global Health Systems

In the wake of the struggle against colonialism after the Second World War, a new market-oriented development model emerged as a process of restoration and hope for the western nations devastated by the Second World War and in the context of a rising decolonization movement where the previous “civilizing/modernizing” mission of Europe was no longer possible (Cooper& Packard, 1997; Jalée, 1970; Quarles & Giri, 2003). Thus, ideas of "Development Assistance," "Aid" and "International Loans" were born. The concept of development assistance and loans emerged from the International Monetary Conference held at Bretton Woods in 1944 with the aim of reconstructing Europe. The outcome of this conference was the creation of the World Bank and the International Monetary Fund (IMF). Since their conception, these financial institutions have been focused on the interest of the industrial economies and the reconstruction of devastated Europe (Hancock, 1989; Hobart, 2002).

The gradual shift of development and aid from Europe to what westerners later termed as "underdeveloped" countries occurred as a result of Resolution 200 declared at the UN General Assembly in 1948 and US President Harry Truman's "Point Four Plan" (Ayittey, 1998; Hancock, 1989; Jalée,1970). The plan called for support for underdeveloped areas of the world as part of the humanitarian and moral virtue of western nations. Henceforth, the idea of “Foreign Aid” took shape and its purpose as commonly designated by donors or lenders came to be known as “Development” (Ayittey, 1998; Hancock, 1989). Later in the 1950s until the 1980s development agendas specifically in the US also sought to push back against communist ideologies and promote imperialism and capitalist spheres of influence in the world. As other scholars have pointed out, the motives and intentions behind development assistance were not just humanitarian but also business-oriented and ones that allowed funding institutions and nations to maintain their position of influence and control around the world (Ayittey, 1998; Hancock, 1989; Hobart 2002; Packard, 1997).

Western nations, therefore, devised business model loans and funding schemes that would allow industrialized nations to benefit from development programs. Major international financial institutions that carry out these development strategies at the global level are the World Bank, International Monetary Fund (IMF) and the former General Agreement on Trade and Tariffs (GATT) which was replaced by the World Trade Organization (WTO) in the 1940s. Later, from the 1960s onward until today western nations have developed international development agencies and programs such as USAID (United States Agency for International Development) and DFID (Department for International Development, UK) among others to manage global economic

development programs. These are some of the key organizations that currently institute and implement development agendas globally. The market-oriented development concept promotes engagement in the market for economic growth in order, it is claimed, to alleviate poverty and foster social change in the developing nations. This model defines poverty reduction only in light of participating in the market economy and consuming commodities from the global market (Shiva, 1988/2010). Hence, public services such as health care are considered untapped market opportunities and commodities to be sold. As a result, free public services for the poor such as health care, medical supplies and drugs are now privatized or sold at a cost.

Global development after the Second World War was thus a "post-colonial," one-size-fits-all form of progress modeled after western economic commercialization and capital accumulation that non-western nations are often compelled to follow (Shiva, 1988/2010). These arrangements of economic growth and progress maintained a global hierarchy between wealthy and poor nations through aid and loan programs similar to those of colonialism. The wealth, knowledge and resources of non-western, third world nations continued to be exploited and devalued (Chambers, 1983; Shiva, 1988/2010; Smith, 2012). Global economic development thus serves as a modern-day tool for the continued oppression of poor, marginalized populations in third world nations and the suppression and exploitation of their knowledge, health and wealth. In Africa, in particular, the new market-oriented development agenda substituted for colonization. Development became the means through which former colonial governments sought legitimacy and cooperation from former colonies (Hobart, 2002). Colonies eventually

became "underdeveloped"/ "third world" nations in need of aid from western "developed" nations or previous colonial governments (Hancock, 1989).

Maternal Health-Related Economic Development Strategies

The Structural Adjustment Programs (SAPs) are one of the major development strategies western nations imposed on third world nations in the 1970s to enhance market deregulation, privatization and "development" based exploitation. SAPs are austerity measures designed by the World Bank in the form of loans and policy reforms imposed on third world nations which are believed to have "mismanaged" their economy and which are unable to pay their financial debts (Ayittey, 1998; Fort et al. 2004; Gloyd, 2004). The health sector was no exception to the SAPs underway in third world nations.

Global economic development policies such as the SAPs have had a negative impact on health in general and the reproductive and maternal health of women in particular (Pandolfelli et al., 2012). World financial institutions and industrialized nations have been coercing third world nations since the 1990s to cut back on financing their health services in order to pay their national debts (Evans, 1995; Grown et al., 2006). This has led developing nations to adopt "health finance reforms" that impose user fees for maternal health services on poor populations and have increased the prices for medical equipment, drugs and kits required for obstetric care. In a recent cross-national analysis of research on Sub-Saharan African countries receiving SAPs, the study found that Sub-Saharan African countries that received SAPs had high maternal mortalities compared to those that did not receive SAP loans (Evans, 1995; Pandolfelli et al., 2012). In *I would pay in Maize if I could: Trade Liberalization, User Fees, and Women's Health*

Seeking in Tanzania Nanda (2006) provides a glimpse of how Tanzanian mothers face challenges to access the health services due to imposed user fees and their inability to acquire maternal health kits (Nanda, 2006). Government operations in this regard vary across nations. Third world nations often lack the resources to provide maternal health care services and are often blamed for it. The health budget of almost all African countries was less than 5% of their national budget in the 1990s compared to the recommended rate of 10% (Njikam, 1994).

In addition, donor nations use these development strategies as reasons to continuously cut back on the few resources they make available for health often with the justification of "encouraging" third world nations to finance themselves through privatization. In *Macroeconomics and Health,* Sachs (2001) documents the meager amount of finances wealthy western nations contribute for global health spending. The US, for instance, provides less than 0.02% of their GDP for global health initiatives (Sachs, 2001). Despite their contribution of less than 1% in terms of aids and loans, wealthy western nations continue to have a considerable amount of influence in the health policies and strategies of third world nations like Ethiopia.

Critique of the Market-Oriented Development Framework

In the late 1980s, third world governments, feminists, women's health movements, civil societies and various stakeholders all expressed their dissatisfaction with the development assistance frameworks and loan strategies imposed by international financial institutions (Petchesky, 2003). The SAPs promoted by the World Bank and the International Monetary Fund were heavily criticized for the power hierarchies they

created between wealthy and poor nations and for the top-down approach with which policies and loans are established and operated (Grown et al., 2006; Hancock,1998; Petchesky, 2003; Tsikata, 1995). Prominent economists such as Amartya Sen and Joseph Stiglitz have argued that development requires more than just economic growth but also political freedom and the balancing of other inequalities and the opportunity to fulfill one's ‘capabilities'" (Petchesky, 2003, p.146). The World Bank and its SAPs, however, focused on reducing the living standards of the third world populations for the sake of economic growth, market deregulation and debt repayment.

Upon heavy criticism in the 1990s, the World Bank made some reforms to replace the structural adjustment programs with poverty reduction strategies for borrowing developing nations (Hong, 2004). The Bank started encouraging developing nations to prepare poverty reduction strategy papers (PRSPS), with sectoral strategies and implementation plans. In reality, these documents and strategies were more or less the same as the SAPs they intended to replace. In addition, the power hierarchy and influence of the lending countries on policies were maintained (Gloyd, 2004; Petchesky, 2003). Reforms of the Bank continued to be predicated on market economic concepts, trade liberalization and privatizations. For instance, the Bank's report on health investment in 1993 stated that economic growth is a condition for good health, but little was discussed about economic inequalities and social injustices that were fueling the poverty and ill-health of the masses in third world nations (Hong, 2004).

Sector-Wide Approach for Health: Alternative to Improve Aid Recipient and Donor Relations

As mentioned earlier many third world nations attempted to create self-reliant, people-centered models of development and health programs and policies despite heavy impositions of global economic development agendas. Third world governments did work towards accessible health care for their populations despite the legacy of colonial health systems and global economic challenges, (Hong, 2004). Countries like Cuba, Vietnam, Sri Lanka, Tanzania and China made great efforts to provide an equity-oriented health service for their populations through community-based health initiatives (Ibid).

Various groups including third world governments, civil society organizations and non-governmental organizations (NGOs) proposed alternatives to how aid and loans are managed in the developing nations and in the poverty reduction strategies the World Bank established (Cassels,1997; Peters et al., 2013). One alternative suggested by WHO technical experts in the late 1990s to bring about aid effectiveness in health is the Sector-Wide Approach (SWAP). The framework was later included in the declaration of the UN high-level forum meeting in Paris in 2005. SWAP is a form of partnership between borrowing and lending institutions and nations where borrowing governments are meant to take the lead in policy formulation and in setting up priority areas to be addressed in their development plans. It also includes reforms for the management of development assistance where donor countries and aid-receiving nations would work in partnership to address implementation challenges and fund management (Peters, et al. 2013). SWAP was designed to harmonize program areas and funds allocated for the programs in a way that will avoid duplicated efforts and a waste of resources and labor for borrowing and

aid recipient nations. The adoption of SWAP represents a departure from the strongly criticized, fragmented and ineffective project-based development strategy to a primarily government-owned sectoral development plan. SWAP is designed to allow loan and aid-receiving nations to fully take part in the policy, decision-making and fund management and monitoring process (Cassels,1997; Peters et al., 2013).

Some assert that SWAP has not brought about significant change to the way funds operate in many third world nations and that similar to the strategies employed in SAPs, the SWAPs also are centered on donor interests far from removing the power hierarchy (FMOH, 2013a; OECD report). However, as we will see further and in the next chapter, the Ethiopian experience with SWAP has been slightly different. Even though Ethiopia is still in many ways complicit with funding modalities of international donor nations and their political interests, SWAP frameworks have created room for the Ethiopian government to become more vocal and to a certain extent establish its policy priorities in a context of constant global and local economic pressure and domination. The following section addresses early health, development and modernization ideas and policies in Ethiopia and the ways in which global development and modernization discourses have shaped previous and current health policies of the nation.

Feminist Critique of Development

Feminist movements have been among the key driving forces behind the favorable changes the world has experienced in global development and health discourses and the resistance against global economic pressures. Feminist critique of the global capitalist market orientation and deregulation has been instrumental in reforming and changing many development agendas (Kaplan & Grewal, 2001; Mohanty, 2003; Shiva,

1988/2010). The very fact that women's economic and reproductive health issues have even been considered as a priority in global development and health agendas is a result of countless advocacies, protests and resistance of feminist and other social justice movements against the global patriarchal, capitalist development system (Petchesky, 2003).

Various studies have shown that women bear the heavier brunt of poverty caused by global processes of development and economic growth (Hawkesworth, 2006; Petchesky, 2003; Shiva, 1988/2010). Many women in the world have lost their lands and their means of livelihood due to commercial farming and trade. Some have lost their right to resources such as food crops and their rights to ownership of some commodities and knowledge as a result of global patent rights (Beneria et al., 2000; Carr et al., 2000; Shiva, 1988/2010). They also make up the majority of the flexible, cheap and highly exploited labor force that is fueling the industrialized economy (Ibid).

As noted earlier, globalized economic and development schemes promoted by international financial institutions such as international trade liberalization, privatization of public services, major cutbacks in public welfare spending in the form of financial reforms and SAPs have direct and indirect impacts on the reproductive lives of men and women in the Global South and North (Grown et. al, 2006). Direct impacts include birth defects or infertilities caused as a result of toxins in workplaces and living areas (Amin, 2006; Grown et al., 2006). They also include the imposition of user fees through health finance reforms, access and distribution of drugs, family planning and reproductive health services, or impacts related to women's employment in the globalized economy (Nanda, 2006).

There are also indirect impacts of market-oriented global economic development frameworks on women's health and wellbeing (Grown et al., 2006). In spite of being the major agricultural producers in the world (60-80%), women -particularly third world women- earn a tiny portion of the profits from agricultural products and their contribution is often invisible (FAO, 2013). Beneria et al. (2000) and Carr et al. (2000) similarly note that women in the developing nations live in dire conditions catering to multinational corporations and industries that exploit their labor and their lands. As a result, women in developing nations suffer from persistent poverty, hunger and low agricultural productivity due to the large focus on cash crops produced to benefit the western market (Hartmann, 1995).

As recent transnational feminists have duly noted in their work, a feminist critique of development requires an integrative approach providing a holistic view and analyzing the various dimensions of power and showing the complexity of women's experiences in global development processes (Aguinaga et al., 2013; Grown et al., 2006; Shiva, 1988/2010). Various forms of feminisms across the globe have challenged development frameworks that emerged after the second world war (Aguinaga et al., Grown et al., 2006; Mohanty, 2003; Petchesky, 2003). In the 1970s, feminists such as Boserup and others "questioned the outcomes of post-1945 development programs, showing that they had serious implications for women's participation and well-being" (Aguinaga et al., 2013, p.42).

Initially, feminists critiqued the development agenda for completely ignoring the participation and contribution of women in the economy of their nations. Women were considered passive recipients and dependents (housewives and mothers) of their

household with men as breadwinners and primary targets of development programs (Aguinaga et al., 2013). This western-imposed development household/family model was disseminated in development programs operating in many third world nations (Kaplan & Grewal, 2001). The early feminist critique of development resulted in the inclusion of women in development programs through the Women in Development (WID) and Women and Development (WAD) frameworks (Aguinaga et al., 2013; Brown, 2006). These frameworks emerged after the international women's conference in Mexico in the 1970s and primarily focused on including women in pre-established development agendas and making development funds available for women. Women's contribution to the productive economy was recognized and they were also targeted as untapped resources for better economic development. WAD advocates argued that women's reproductive work in the private domain has not been considered as an economic and development contribution (Aguinaga et al., 2013). Hence, this framework also mainly focused on including women in the overall economic process.

However, both WID and WAD frameworks did not challenge the overall structures of development programs and only worked to remove the exclusion of women from these agendas. Both WID and WAD emphasized productive work, paying little attention to the reproductive labor of women and the additional work burden this creates for the majority of women in the Global South (Aguinaga et al., 2013). Both frameworks have also been criticized for being western-oriented and failing to see the cultural, gender and family dynamics in the Global South (Kaplan & Grewal, 2001). In the following years, feminists further critiqued patriarchal, market-oriented, capitalist development frameworks that are based on the exploitation of women in the Global South and North,

using them as primary targets of the development agenda (Aguinaga et al., 2013; Brown, 2006).

In the 1980s, other relatively holistic approaches materialized as a result of transnational, socialist, third wave feminist movements that challenged both patriarchy and capitalism. A Gender and Development (GAD) approach and an Alternative approach to development were formed among others. The GAD approach focuses on the gender division of labor and the power relations and social constructions between the sexes and the structural inequalities that result from gendered social relationships. However, this approach was also criticized for paying too much attention to the social differences between the sexes without the analysis of the bonds between them. In addition, many programs that employ the GAD approach even though theoretically distinct, were basically WID and WAD oriented in their program implementations. The Alternative approach emerged in Latin America and has questioned the homogeneity of women as a category and their experiences across the globe. It stresses the need to look at women's experiences as not only shaped by gender but also by other intersectional categories of oppression such as class, race, ethnicity, sexuality (Aguinaga et al., 2013). Many feminists in different nations in Latin America, Africa and Asia have employed similar approaches to create alternative development frameworks (Aguinaga et al., 2013; Beneria, 2016).

Using various approaches, feminists have questioned various global development and health policies and have been able to formulate global development frameworks that are more or less comprehensive. Despite the lack of adequate and effective implementation, the comprehensive definition of reproductive health at the ICPD, and

gender equality and maternal health pledges in the MDGs as we will see further are examples of improved development agendas and the results of the feminist critique of development related to maternal and reproductive health.

Global Maternal Health Initiatives and Reproductive Politics

The Ethiopian Health Policy in general and maternal health strategies, in particular, are predicated on and backed by some global initiatives that have shaped the policy's visions and implementation. Key international initiatives have emerged over the years including WHO-led safe motherhood programs and making pregnancy safer campaigns of the 1980s, the International Conference on Population and Development in 1994 (ICPD), the MDGs in 1999 and the SWAP that was officially declared at the Paris high-level meeting for aid effectiveness in 2005. The ministry's documents I have reviewed state their objectives and targets in relation to these international development initiatives and. Therefore, I will discuss these global events and initiatives to explain the context in which the current maternal health strategies emerged in Ethiopia.

In the 1980s, maternal mortality was termed a "neglected epidemic" (Anderson, 2009; Pacagnella et al., 2012; Rosenfield & Maine, 1985). Despite the shocking rates of women dying from what is mostly a preventable phenomenon, various authors affirm that maternal health complications and maternal mortality were only recognized as a serious challenge globally in the 1980s (Anderson, 2009; Gruskin et al., 2008; Nasah et al., 1994; Pacagnella et al., 2012; Petchesky, 2003). To be more specific, it was the 1985 article "*Where is the "M" in MCH* (Maternal and Child Health) programs" by Rosenfield and Maine (1985) that clearly presented the lack of international attention given to a global challenge that was taking the lives of more than 500,000 women a year in third world

nations. Rosenfield and Maine (1985) explained how maternal and child health programs globally only focused on the health needs of infants and children with simple preventive strategies designed to address immunization, oral rehydration, breastfeeding, growth and malnutrition. The program component that was intended to address women's health issues was family planning and food supplements in times of malnutrition. The absence of basic and emergency comprehensive obstetric care in MCH programs was evident. Maternal health initiatives were lagging behind and countless lives were being lost every day (Gruskin et al., 2008).

Two years later in 1987, the international conference on Safe Motherhood was held in Nairobi to discuss women's health and mitigate maternal health complications. UN member states met at this conference and for the first time, maternal health issues were raised as a global public health concern. Following this event governments, international agencies including WHO, the World Bank and UNFPA and other non-governmental organizations established the Safe Motherhood Initiative (Rosenfield, 1997). Maternal mortality estimates were also calculated for the first time globally and nationally exposing the huge gap between women in rich and poor nations (Gruskin et al. 2008; Rosenfield, 1997). Safe Motherhood programs allowed nations like Ethiopia to prioritize maternal health problems and devise strategies to address them. Ethiopia's Making Pregnancy Safer and Safe Motherhood Initiatives were designed in response to the recommendations of this conference to address high incidences of maternal mortalities and morbidities in developing nations.

The ICPD 1994 was another pivotal moment where reproductive health was redefined to include comprehensive maternal and obstetric care that would allow mothers

and their families to go through pregnancy and childbirth safely in addition to the preventive and spacing options of family planning services (Gruskin et al. 2008). At the ICPD, third world governments and non-governmental organizations, transnational women's health movements and various feminist groups from the Global South and North played a key role in demanding comprehensive reproductive health services and re-defining sexual and reproductive health rights (Corradi & Vingelli, 2008). Hence in the 1980s and more intensively in the 1990s population institutions and governments that are influenced by these institutions were compelled to include maternal health issues in the reproductive health agenda (Petchesky, 2003).

Various international maternal health campaigns and programs began to emerge after the ICPD (Anderson, 2009; Johnson, 2014; Petchesky, 2003). There was a renewed global consensus to improve maternal health (Bedford et al. 2012). The MDGs are among these major interventions initiated by governments and non-governmental organizations after the ICPD. The MDGs are the pledge of 189 nation-states and international organizations after the UN Millennium Summit to achieve eight goals to eradicate poverty and improve the health and wellbeing of the world's poor by the year 2015. MDG goals 4 and 5 stated the pledge to reduce maternal mortality by three-fourths and promote gender equality and empowerment (Adjiwanou & LeGrand, 2014; Anderson, 2009; Johnson, 2014). These initiatives led to increased global awareness about maternal health challenges of women particularly in the developing nations (Anderson, 2009).

However, the success of the above-mentioned initiatives and pledges can only be measured by the actual implementation of maternal health programs worldwide. Anderson (2009) notes that the transnational movements have not resulted in the increase

of global support or the improvement of maternal health outcomes for most women in the Global South. The very fact that maternal mortality has remained the same in many places in the world reveals the challenges in the implementation of the programs and policies above (Anderson, 2009; Berhan & Berhan, 2014). One wonders why maternal health was not on the reproductive health agenda before the 1980s or more importantly what was the main reproductive agenda then and what factors created the shift towards including comprehensive reproductive health and maternal health programs in the agenda. This is a very crucial question that reveals how maternal health is engaged in global and local reproductive health policy frameworks.

One reason why maternal health was not a major priority prior to the 1980s was because the focus of reproductive health programs globally was on population control strategies such as family planning programs as "preventive measures" to limit and control the fertility of women in third world nations and ethnic minorities in the West (Hartmann, 1995; Petchesky, 2003). In her acclaimed book *Reproductive Rights and Wrongs: Global Politics of Population Control*, Betsy Hartmann (1995) provides a well-researched account of population policies and the global reproductive health politics. Hartmann (1995) discusses 18th and 19th-century "population explosion" theory of Thomas Malthus and his proponents that are still relevant among global population theorists, environmentalists and population institutions, government and non-governmental organizations. As stated earlier, the Malthusian theory asserts that a population that is not regulated would double every twenty-five years causing hunger, poverty, environmental degradation and resource depletion in the world unless it is regulated (Connelly, 2008; Lee & Feng, 1999; Hartmann, 1995). Fear of overpopulation and more importantly

overpopulation of the world with the “unfit” races compelled proponents of this theory to promote the regulation of fertility and the need to control population (Connelly, 2008; Hartmann, 1995).

Modern-day proponents of the Malthusian theory employ their racist, sexist and classist agenda implicitly and effectively on Third World nations and ethnic minorities in the West (Hartmann, 1995; Lee & Feng, 1999; Takeshita, 2011). Neo-Malthusians and the later population growth or demographic transition theorists and environmentalists link higher birth rates or “overpopulation” to lower living standards in Third World nations. According to these theories food scarcity, environmental degradation, diseases, poverty, famine, war and other problems of the world are attributed to overpopulation in non-western nations without due analysis of the historical, social and political contexts of these nations (Greenhalgh, 1995; Hartmann, 1995; Koblitz, 2014; Lee & Feng, 1999). Hence justified by these "scientific" ideas of progress and development, population control efforts became commonplace on a global scale (Connelly, 2008; Lee & Feng, 1999; Hartmann, 1995).

Various authors have exposed the flaws of Malthusian theory illuminating the sexist and racist intentions of those who promote this agenda globally (Connelly, 2008; Lee & Feng, 2008; Hartmann,1995; Koblitz, 2014; Petchesky, 2003; Takeshita, 2012). Hartmann (1995) for instance exposes how the theory does not account for the historical legacies of colonialism, showing how it is selectively applied to specific groups mainly third world women and ethnic minorities in the West in the effort to control their fertility. She explains how the theory is used “as a weapon of cultural genocide through the forced sterilization of Native American women in the United States and ethnic minorities in

South Asia" (Hartmann, 1995, p. 37). Sterilization of women in Puerto Rico, India and the recent mass sterilizations of Sub-Saharan African women are among such examples (Briggs, 2002; Hartmann, 1995, p. 37).

Hartmann (1995) provides the context in which women, specifically third world women, choose to have a large number of children. Hartmann cites the historical legacies of colonialism that reduced third world populations and disrupted traditional methods of birth spacing, high infant mortality and limited agricultural productivity as being major reasons as to why women in third world nations decide to have a large number of children. Many scholars have also presented counter evidence to the environmental degradation and resource depletion problems that are attributed to population growth in third world nations. These scholars argue that high energy consumption, environmental degradation and resource depletion occur as result of the activities and policies of rich industrialized nations and not the subsistence living and farming population of poor third world nations (Connelly, 2008; Lappé & Collins, 1998; Lee & Feng, 2008; Hartmann, 1995; Shiva, 2000).

Recent studies affirm that population control efforts are currently underway in different national and international reproductive health and population policies. Population control theories are widely adopted by western and non-western governments and population reduction-focused institutions. The USAID, World Bank, Population Council, International Planned Parenthood, and Ford Foundation are among many others who are currently providing global reproductive and maternal health services and support (Connelly, 2008; Takeshita, 2011). As mentioned above, at the 1994 ICPD conference, women's health movements, various governments and organizations exerted pressure on

population institutions who were promoting population control policies. They challenged uneven distribution of funds towards family planning services and the lack of attention paid to a comprehensive reproductive health plan for third world nations (Petchesky, 2003; Takeshita, 2012). However, with simple name changes and rhetoric on policy documents, many reproductive health services funded by population institutions and international funding agencies have remained the same regarding their priorities for funding in the plan of action of the ICPD. Funding primarily focused on preventive measures of family planning rather than basic and emergency obstetric care (Petchesky, 2003).

Therefore, the outcome of the ICPD and the main agenda globally and nationally became limiting fertility as compared to providing comprehensive maternal and reproductive health care regardless of the interests and needs of third world nations and their women. The Ethiopian maternal and reproductive health agenda is also influenced by the above mentioned global initiatives and policy frameworks. There seems to be a similar but complex pattern in terms of population control policy frameworks and the need and desire to provide comprehensive reproductive health care in the Ethiopian context that I will explain further in this chapter.

Early Health, Development and Modernization in Ethiopia

Ethiopia, seems to have a long-standing ambivalence-both acceptance of and simultaneous resistance- toward western modes of development. This is reflected in the evolution of the health system over the years and the establishment of development narratives and modern health strategies and interventions. The expansion of western modernity globally, 19th-century development and modernizing ideas brought by

missionaries and diplomats from the West, anti-colonial resistance and temporary colonial occupation played key roles in shaping Ethiopia's health system. As early as the 16th century and mainly in the 19th century, various foreign diplomats and missionaries from Portugal, Italy, Britain, France and Russia came to Ethiopia and introduced western medicine and modernization ideas to the kings and nobility (Kitaw et al. 2012). In the 19th and 20th century Ethiopian monarchs developed a keen interest in western modern technologies and social development despite their resilient anti-colonial resistance (Kitaw et al. 2012).

Nineteenth-century emperors of Ethiopia in particular sought modernization and progress for the nation. Emperor Tewodros II (1855-1868), who was eager to modernize and unite Ethiopia, was also very much interested in the introduction and expansion of western medicine. In his zeal to modernize his country, the Emperor even went as far as imprisoning and forcing British and German missionaries to build him a modern artillery mortar nicknamed Sebastopol. He had done so since his request for assistance from the British Empire was ignored. He later died fighting the British military expedition that came to rescue the missionaries (Pankhurst, 1998; Zewde, 1991). His successors Emperors Yohannes IV and Menelik II, despite their prominent anti-colonial struggle against Europeans and their suspicion of missionaries and diplomats, also strived to introduce modern education, health and technological advancements of the time to the Ethiopian people. Both Yohannes IV and Menelik II, for instance, took the smallpox vaccine in an effort to convince the people to do the same during the smallpox epidemic. Also, decrees were sent out to the people in the capital city to be vaccinated (Pankhurst, 1965; Kitaw et al. 2012).

The enthusiasm of the kings toward western medicine and development at large may be due to two factors. Even though the kings were quite skeptical of colonial powers and their motives, the wealth, health and development that western nations had amassed over the years were something poor non-western nations like Ethiopia desired for their populations. On the other hand, one can argue that western diplomats and missionaries of the time had succeeded in their strategic imperialist projects of establishing western superiority, knowledge and modes of social development in Ethiopia as they have done in other countries in Africa.

At the same time, Ethiopian kings in the 19th and 20th centuries pushed back against the colonial and imperial pressure that had hindered the progress and expansion of health services to the masses and the colonial model of health expansion that did not take into account the socio-cultural context, and the traditional health practices of the people. Since the establishment of the first hospital during the reign of Emperor Menelik II there was a strong push for integrating traditional health practice and medicine along with western medicine. Mehari et al. (2012) note that "Although appreciative of the virtues of foreign medicine, Menelik seemed to encourage allopathic medicine only so long as it maintained a compromising stance toward indigenous therapeutics" (Mehari et al. 2012, p.16). The Russian Medical Mission that came to aid Ethiopia after the Battle of Adwa was asked by Emperor Menelik II to produce an Amharic medical textbook that included both western and local methods (Kitaw et al., 2012). The emperors' efforts to integrate indigenous practices may have had a lasting impact on the preservation of these practices by Ethiopian society. Today a majority of Ethiopians still rely on traditional health practices and medicines (Kassaye et al., 2006). Also, the health policies that were

established during and after imperial rule have had a favorable outlook towards these practices. The health policies to date have a section that deals with traditional medicine and practice and have established an association to that effect (Bishaw, 1991). However, as we will see, implementation and integration of these practices into government health policy have gradually decreased as modern medicine became commonplace and Ethiopia slowly shifted its political agenda to modernization and later economic development.

From 1935-41 during the Italian occupation and the Second World War and from 1941 until 1948, Italians and the British were respectively in charge of the health administration in Ethiopia. During this time there was no organized health system. Hospitals were built for the white population and the little health facility expansion done in rural districts was more of colonial dispensaries that the people and the local governors were skeptical of (Kitaw et al., 2012). Despite the colonial and foreign pressure, the emperor at the time, Emperor Haile Selassie I (1930-74), tried to establish a more organized health system. In 1948 Ethiopia established the Ministry of Health. As a member state both of the United Nations and the World Health Organization, Ethiopia took on the task of expanding its basic health services by improving the decentralization of the health systems and by establishing a network of units such as health centers, sub-centers and health posts that would reach the community and that would undertake preventive and curative services in the areas of maternal and child health, communicable diseases, environmental health, health education, etc (Ibid).

In a poor country devastated by colonial war, the government's effort to expand health services to the masses is commendable. The emperor focused on building schools and hospitals. The first medical school, nursing school and medical midwifery school

were also opened during the time of Haile Selassie I[14]. This shows how eager the emperor was to modernize the nation and to have many trained Ethiopian medical professionals who would treat the masses. Consequently, scholars that document the history of modern medicine in Ethiopia praise the kings of the 19th and 20th centuries for being "modern-minded" and for promoting western health service provision and medicalization in an effort to provide basic health services to the population (Kitaw et al. 2012; Mehari et al. 2012).

However, in addition to acknowledging the kings' efforts to expand modern health services, I argue for a more nuanced discussion of how modernization, development and medicalization narratives have become pervasive over the years in the process of modernization and examine what that entails for traditional health-related knowledge of the community and more specifically for traditional maternal health practices today. I also advocate for a better understanding of the impact development and modernization discourses have on current maternal health policies.

Post World War II Global Expansion of Health Services and the Primary Health Care Period

The end of the Second World War brought about two major developments that have shaped Ethiopia's health system. The first one is the end of Italian occupation and British supervision. The second one is the establishment of the World Health Organization (WHO) in 1948 which led to the formation of the first Ministry of Health in Ethiopia. At the time when the world was dealing with various diseases after the second

[14] He is also known for leaving his palace to establish it as the first university in the nation, the now Addis Ababa University is still in the former palace of the Emperor Haile Selassie I.

world war nations came together to establish the WHO. The WHO was established to assist nations (technically and financially) in building and expanding their basic health services which meant providing adequate health coverage for the population at risk of major epidemics and diseases of the time (WHO,1959; Kitaw et al., 2012).

The establishment of the WHO is a major international development that has strengthened and positively impacted health initiatives in poor non-western nations like Ethiopia. Such platforms, although they were western dominated in political interests, allowed for nations from the Global South to organize, share experiences and voice their concerns and address some of their health challenges despite the minimal resources that were made available (Hong, 2004). However, over the coming decades in the 1950s and 1960s with minimal resources allocated for social services the effort of WHO[15] and poor non-western nations to expand health services for larger populations continued to diminish (Hong, 2004). One has to see these global and local health challenges after the Second World War in the context of the market-oriented, economic development plans that took place with the establishment of the world financial institutions.

In the late 1960s and 1970s in the context of the Cold War many countries, including Ethiopia, realized that they had failed to reach the majority of their populations through a basic health services approach (Hong, 2004; Mehari & et al., 2012). Hence, many developing nations including Ethiopia sought to establish nationwide community-based health projects emulating model community-based health interventions in other countries such as China, Vietnam and Cuba (Cueto, 2004; Kitaw et al. 2012). In 1978 at

[15] With limited resources provided for technical support, WHO continues to experience a lack of power to decide on global political issues that impact the health of many people. Thus, WHO often only serves its technical purposes rather than a political one (Abassi, 2014).

Alma Ata, the World Health Organization and representatives of 192 member states proposed a social justice approach to health declaring “health for all by the year 2000.” Primary health care for all was predicated on the principles of equity in health. After the Alma Ata declaration, the world was compelled to look at health as a human rights and social justice issue at least in rhetoric. The declaration emphasized the need to address inequality in the distribution of health resources between and within countries (WHO, 2009). This was the first time issues of social and economic development that impact the health of poor nations were raised. Maternal and child health were among the six key health components addressed in the primary health care approach. The primary health care approach was designed to bring comprehensive health care as close as possible to where people reside and work and this required political and economic commitment and active community participation (Kitaw et al., 2012).

However, it was not long before donor countries and population institutions and corporations globally attacked and criticized the WHO for the "health for all approach" and what they believed was an unrealistic and costly intervention (Hong, 2004). Hence these institutions suggested that selective primary health services be implemented globally, targeting specific forms of diseases and "at risk" and vulnerable populations. International funding and population institutions provided scant resources for a few selected health programs and viewed the overall primary health care intervention as impractical (Ibid). The reluctance of international funding institutions to provide funds for the primary health care approach mainly was due to their market-oriented, economic development plans.

Ethiopia's Primary Health Care Period

The primary health care approach was adopted in Ethiopia after the Ethiopian Monarchy ended in 1974. Emperor Haile Selassie I (the last king of the Ethiopian Empire) was overthrown by a military coup that took place in 1974. After the 1974 revolution, Derg (the Socialist Military Regime) took over. From the moment the Derg regime took over until when it ended in 1991, the period was referred to as the "primary health care" period. The country's political agenda of *"Ethiopia Tikdem"* or "Ethiopia first", which referred to placing the needs and interests of the masses over the interests of the few, and the global health declaration of "health for all by the year 2000" at Alma Ata in 1978 went hand in hand (Kitaw et al., 2012). The Ethiopian government implemented the primary health care approach in one ten-year and two five-year plans. The key components of the plan included disease prevention and control, expansion of health services, self-reliance and community involvement in health activities, as well as ensuring "the provision of comprehensive health services to special population groups, such as mothers and children, students, under-privileged nationalities, workers, etc." (Kitaw et al., 2012, p.108).

For the first time in Ethiopia, maternal and child health was recognized as one of the key components of the health policy and service provision. The specific plan to address maternal health issues was also quite comprehensive with the aim of providing pregnant women with antenatal and postnatal care, child delivery, counseling and family planning services at all levels with an affordable cost of care. The public health approach in Ethiopia meant that the people/community at the time would be responsible for identifying their health needs and how the health system should be organized. The policy

also created favorable conditions for the development and preservation of traditional medical knowledge and practitioners. Even though little was mentioned about traditional birth attendants, overall the policy and implementation plan proposed improving and promoting traditional medicine and training indigenous medical practitioners (Bishaw, 1991; Mehari et al., 2012; Kassaye et al., 2006; Kitaw et al., 2012).

Similar to other third world nations that attempted to provide primary health care for their population, Ethiopia's effort to improve the overall health system and maternal health services, in particular, were met with major difficulties. Lack of economic resources, the cold war that was taking place abroad, a civil war that lasted 17 years, famine and other socio-political problems in the country seriously affected health service provision in Ethiopia. Maternal mortality rates at the time when the *Derg* socialist regime ended in 1991 was the highest ever recorded in Ethiopia. In the early 1990s, maternal mortality was as high as 1400 per 100,000 live births (WHO, 2015).

Current Ethiopian Health Policy and the Health Sector Development Program

When the current ruling party EPRDF overthrew the Derg regime and established a federal government in 1991, the government created a developmental state[16] with a free market economy partially regulated by the state. The nation's development strategy is an economic reform program under way since 1992 established with the support of the World Bank and International Monetary Fund with a series of SAPs (Government of

[16] Woldegiorgis (2014) explains the initial definition of the developmental state as follows "Chalmers Johnson, arguably the most cited author on the subject, introduced the phrase 'developmental state' in his 1982 seminal book: *MITI and the Japanese Economic Miracle: The Growth of Industrial Policy, 1925– 1975*. Johnson used it to differentiate between alternative types of capitalism, where also he questioned the conventional view on the role of state in economy. In his argument, Johnson pointed out that the state was at the center crafting and coordinating the Japanese 'economic miracle' (Johnson, 1982, 1999). This came as a major blow to the laissez-faire narratives, which were inclined towards putting the contribution of the state and politics, in economic growth and development, as negligible or even negative" (Woldegiorgis, 2014, p.3).

Ethiopia [GOE], 2016)[17]. Ethiopia is among the aid and loan recipient nations. The government presented a policy reform paper to the World Bank and the International Monetary Fund in 1992 and obtained SAP loans through the regional African Development Bank. Since then a number of economic reforms have been underway including privatization of state enterprises, market deregulation and limited government regulation (FMOH, 2010). As a result, the nation continues to be impacted by global trade conditions, market liberalization and deregulation processes as part of the market-oriented development plan.

Like other third world nations, Ethiopia's plan to alleviate poverty and bring about economic growth is based on loans and aid from the international institutions. Similar to other scholars who have written about the global economic agenda, I contend that this is not the choice of poor nations but a socio-economic and historical phenomenon imposed on them. Short of authority, poor nations have no option but to seek loans and aid to survive in the global market and to address the deep-rooted poverty they reside in.

Ethiopia's overall policy reform and the shift towards a developmental state after 1991 shows the global economic development discourse with which the Ethiopian state is currently operating. Ethiopia's development plan is based on an agriculture-led industrialization and export-oriented development with the leadership of the government and the partnership of the private sector.[18] The government controls and manages larger sectors such as banking and communications and part of the social sectors such as health and education. There is a strong push to deregulate and privatize sectors and in many

[17] Government of Ethiopia [GOE].(2016). Government Portal: Policies and Strategies. Retrieved from http://www.ethiopia.gov.et/policies-and-strategies1
[18] Ibid

ways, Ethiopia has succumbed to the global economic pressure. However, when it comes to the health and education sector, the government has consistently strived to maintain leadership and provide community-based health services to its population despite these overarching development discourses of liberalization.

The National Health Policy

Various changes have taken place amidst the political transition in the past 26 years. The formulation of new social sector policies is among the changes that took place. The two policies established in the early 1990s that are pertinent to maternal health are the population and health policies. In 1993 the transitional government of Ethiopia's Federal Ministry of Health developed the current health policy (FMOH, 2013a). The main objective of the document is to establish an equitable and fair health care system with the full participation of the population (Ibid). The current policy, similar to the previous policy of the *Derg* regime, draws on the primary health care approach to ensure access to basic health care packages for all segments of the population. The difference between the two policies lies in the current policy's emphasis on the health extension program to the rural masses and the detailed twenty-year plan and strategy to execute it. In addition, specific priority areas outlined in the policy's section 8.1 include the need to pay special attention to the health needs of women and children. The general strategy to address maternal health issues is described under section 10 as,

> [a]ssuring adequate maternal health care and referral facilities for high-risk pregnancies. Section10.2. Intensifying family planning for the optimal health of the mother, child and family. Section10.3. Inculcating principles of appropriate maternal nutrition. Addressing the special health problems and related needs of adolescents. Section 10.8. Encouraging paternal involvement in family health and

10.9. Identifying and discouraging harmful traditional practices while encouraging their beneficial aspects.[19]

These policy statements are noteworthy for demonstrating the emphasis given to maternal health in the current policy and the comprehensive nature of the strategies with which the government is planning to address maternal health issues. The government's effort to provide comprehensive community-based health services is commendable in spite of the global development plan to privatize social sectors and the global push back against comprehensive reproductive health services (Petchesky, 2003).

In order to implement the policy, the ministry designed the Health Sector Development Programs (HSDP I through IV). The Health Sector Development Plan (HSDP) is a twenty-year plan divided into 4-terms of five-year plans designed to implement the health policy and were underway from 1994 until 2015. All the regional states of Ethiopia implement the HSDP in their respective regions. Currently a new phase is underway into a similar but new five-year development plan called Health Sector Transformation Plan (HSTP 2015/2016-2019/2020) since the twenty-year plan has been completed[20].

Major strategies of HSDP include building and expanding health facilities, enhancing access to health facilities and necessary medical and drug supplies, training health care professionals, and disseminating health information and education through the

[19] Federal Ministry of Health of Ethiopia.(2012). Policies and Strategies. Retrieved from http://www.moh.gov.et/policiesstrategies.

[20] "The end of EFY 2007/2015 marks the conclusion of the fifth year of the Health Sector Development Program (HSDP IV) covering the period of 2010/11- 2014/15 (EFY 2003-2007). In addition, the wrapping up of the 20th Since its official launching in 1998 G.C (EFY 1990), the HSDP has been continually reviewed through joint exercises as Mid-Term Reviews (MTR), final evaluations, Joint Review Missions (JRM) and Annual Review Meetings (ARM). The present ARM is the seventeenth in the series of annual reviews that took place since the implementation of the HSDP" (FMOH, 2015a, p.3)

health extension program and the improvement of the health care financing, monitoring and evaluation systems. The health extension program is based on a premise of disseminating health information and knowledge to communities and households so that they will be able to maintain their own health and prevent diseases (FMOH, 2013a). The health extension program provides promotive, preventive and selected curative services. This is believed to result in a reduction of health costs and resource spending at the household level which will then be invested productively in other areas (FMOH, 2015a). The nation has made relative progress in health services provision with the help of the health extension program, improved infrastructure, and the training of health professionals.

The five-year HSDP has eight components with specific objectives focusing on: Service delivery and quality of care; Health facility expansion and rehabilitation; Human resource development; Pharmaceutical service development; Information, education and communication (IEC); Health management and Management Information Systems (MIS); Health Care financing; Monitoring and evaluation (FMOH, 2010; Teshome, 2001). Maternal health in Ethiopia is addressed under family health services in the service delivery and quality of care component of the HSDP.

The nation has a three-tiered health system (primary, secondary and tertiary level) with specialized and general hospitals at the top serving about 4 million people, followed by the primary hospitals serving 60,000 to 100,000 people, health centers serving 15,000-25,000 people and the health post as the smallest unit of the health care system reaching

the population at the Kebele level serving 3000 to 5000 people.[21] Hence, every Kebele has a health post. In addition to what was outlined in the health policy and the sector development plan, the ministry has also established specialized organizational units specifically for maternal and child health from the federal, to the regional, down to the Woreda health bureau and Kebele administration levels. The Federal Ministry of Health has a Maternal and Child Health Directorate that oversees national activities and engages with international funding institutions.

SWAP in the Ethiopian Health System

The current health policy and Health Sector Development Programs of Ethiopia (HSDP I-IV) employ the Sector-Wide Approach (SWAP). The government uses this approach to manage its health systems and engage with international funding institutions. Even though Ethiopia is in many ways complicit with global economic development frameworks and aid modalities, SWAP has to a limited extent allowed the Ethiopian government to prioritize key health concerns and to manage the minimal funds allocated flexibly to address those concerns (FMOH, 2013b). For instance, the Ethiopian sectoral development programs and the Enhanced Structural Adjustment Facilities (SAF) submitted to the IMF in the late 1990s clearly stated the government's priorities to improve and strengthen its social welfare services. It also challenged the reduction of public funding to the social sectors (African Development Fund [ADF], 1997; AFRODAD, 2005; GOE, 2016). This prioritization has to a certain extent compelled

[21] WHO (2014). Ethiopia Health Tier System. http://www.aho.afro.who.int/profiles_information/index.php/File:EthiopiaHealthTierSystem.png

donors to reach a consensus on the objectives, strategies, policies, and implementation arrangements of development programs with the Ethiopian government (FMOH, 2013b).

Even though many development strategy critiques and alternative solutions have been ineffective and rhetorical, the Ethiopian government has to some degree managed to use the SWAP framework to promote its policy priority and to push back against donor interests as much as it can. Consequently, there is some tangible evidence of the Ethiopian health system implementing SWAP principles of partnership and aid management. For example, one of the basic principles of SWAP is a partnership in which the level of dialogue between government and donors focuses on overall policy and institutional framework, and is based on the recognition of the ownership and lead-role of the government. Utilizing this core SWAP principle, the Ethiopian government presented in December 1996, to the Donors' Consultative Group meeting, a twenty-year Sector Investment Program (SIP), a move reflecting the government's strategy for expanding access to basic health and education services (FMOH, 2013b; Lister, 1998). This was made to ensure better coordination and focus of international assistance to the sectors through government channels, maintaining the core principles of SWAP (Lister, 1998).

Both government (Annual and Mid-term Review Reports) and other documents affirm that from the initial stage, the decision to embark on SIPs for the two sectors, health and education was entirely the initiative of the Ethiopian government (Lister, 1998; Foster & Nachod, 2000; FMOH, 2013b). The government completed most of the documents and other policy framework preparations before they were presented to the Donors Consultative Group meeting in 1996. The government asked for donors' support only after the decision was made, and it has retained ownership throughout the program

preparation (Foster & Nachod, 2000; FMOH, 2013b, p.28). My discussions with former and current federal health officials also have highlighted that donors voiced some hesitations and critiques about the health sector development plan envisioned by the government to provide healthcare for all. Lister (1998) notes that the government, and not the aid agencies, clearly were the driving force behind the sectoral development plans (FMOH, 1998; Implementing SDPs in Ethiopia, 1998.

In addition, a joint coordination and management plan and, Joint Steering Committees, Joint Coordinating Committees and Pooled Donor funds were established with development partners. Common implementation arrangements were also designed as per the government designed development plan (FMOH, 2013b). In this regard, SWAP relatively represents a step forward towards partnership as compared to previous development strategies and plans where donors had much more mandate in policy formulation, fund management and report. This is not to say that the power hierarchy between donor nations and Ethiopia has been completely reversed or changed, or that Ethiopia is not complicit with global development agendas. Rather, the implementation provides evidence of how the Ethiopian government has tried to create some "wiggle room" amidst donor pressure and a global economic development agenda.

The government-donor partnership is not without challenges. Aid agencies and donor nations still strive to promote and impose their agenda in varied ways. As clearly stated in the 15th Annual Review Meeting of the Ministry of Health of Ethiopia, "Ethiopia has consistently argued for i) its need to be supported by a flexible fund to respond to mutually defined priorities on the ground, ii) its commitment -within its capacity- to provide timely financial and activity reports, and audits as required" (FMOH, 2013b, p).

However, donors responses has been varied, with some increasing their funding levels, while others refused and kept their contribution as before (Ibid). Therefore, the donors' commitment to Ethiopia financially has only been partly respected. As I will discuss further in the next chapter, even though the nation has employed SWAP to maintain ownership of its programs and policy priorities, it continues to face financial challenges to implement the "health for all" policy it has embarked upon.

The way the Ethiopian health system operates in the context of structural adjustment economic policy reforms and its effort to implement alternative frameworks for aid management (SWAP) is complex. On the one hand, the nation has no choice but to depend on funding from aid agencies and donor nations and hence abide by their economic and political interests. On the other hand, the nation has managed to find some leeway to set up policy priorities and promote primary health care policies and in some instances, implement these policies using the SWAP principles. The following chapter further outlines national maternal health-related policies and implementation strategies.

CHAPTER THREE

MATERNAL HEALTH POLICY AND IMPLEMENTATION IN ETHIOPIA

This chapter addresses national maternal health policies, targets and implementation strategies. First, I analyze two main policy documents, namely the Reproductive Health Strategy document of the National Health Policy and the National Population Policy relevant to maternal health in general and family planning and fertility issues in particular. I discuss priorities and paradoxes in these policies related to underlying development and population control narratives that impact maternal health service provision. In the second part of this chapter specifically, I discuss actual implementation strategies and the gaps in addressing the reproductive desires and needs of women. I explore government's innovative, gender-sensitive health extension strategies and women's actual experiences. The discussion includes my observation of practical efforts underway to address maternal health issues, key policy shifts that have changed maternal health service provision, underlying development and modernization narratives in service provision and policy gaps both on paper and at the community level. My work in the field in the Amhara and Oromia regions therefore reflects the connection and dissonance between maternal health policies and strategies outlined on paper and their actual implementation and connection with the desires of women and their community, while critically examining the development discourses in which they occur.

National Health Policy and Maternal Health

The Ministry of Health designed its maternal health programs and implementation strategies within larger global health and development frameworks. In addition to the health policy and HSDPs, the government has incorporated and implemented a number of

global and local maternal health policies and strategies including, Making Pregnancy Safer and Safe Motherhood campaigns (2000), Reproductive Health Strategy (2006), and the Adolescent and Youth Reproductive Health Strategy (2006), the MDGs and the ICPD (FMOH, 2010). The chapter primarily addresses policies and strategic documents supplemented with the findings from interviews and focus group discussions held with women, key informant health service providers and health officials to examine whether the policy targets and strategies address maternal health needs of Amhara and Oromo women.

Global initiatives such as the MDGs, Safe Motherhood Campaigns, and the ICPD, in many ways have influenced local maternal health policies and programs in Ethiopia. Some of the global initiatives such as the Safe Motherhood Campaigns and MDGs have positively influenced national policy documents to be more comprehensive and social justice oriented. For instance, the Ethiopian Making Pregnancy Safer initiative is based on "the principles of equity for women, primary health care and maternal care with four basic components namely Family Planning, Antenatal Care, Clean & Safe Delivery, and Essential Obstetrics Care."[22] This statement is a crucial and all-inclusive one given the global emphasis on programs focusing only on family planning instead of offering comprehensive obstetric care. Such statements highlight the ministry's interest to pay attention to context-specific interventions while accepting and implementing global health initiative.

[22] WHO. (2016). Africa region Ethiopia: Making pregnancy Safer. Retrieved from http://www.who.int/countries/eth/areas/pregnancy/en/

Global health initiatives also have influenced the Ethiopian government to set specific, achievable targets to address maternal health issues. The ministry outlined the following specific targets to achieve MDG goals four and five which are related to maternal health. The specific targets include:

> Reduce maternal mortality rates (MMR) to 267, 101.4 and 45.5 per 100,000 live births by 2015, 2025 and 2035 respectively; Increase skilled birth attendance to 62%, 77%, 95.1% by 2015, 2025 and 2035 respectively; Increase ANC coverage (at least 4 visits) to 86%, 77% and 87% by 2015, 2025 and 2035 respectively; Meet the need for Emergency obstetric care (EmONC): 75% by 2015 and 100% by 2025. [23]

These targets show the Ethiopian government's emphasis on the global pledge of reducing maternal mortality and improving women's health. However, the most recent demographic and health survey and other small-scale studies have shown that the results have so far not matched the above set targets for MMR and that additional effort needs to be made to address mortality rates. The last Ethiopian Demographic and Health Survey (DHS) in 2011 shows maternal mortality figures of 676 deaths per 100,000 live births, with current UN and government estimates of 420. However, multiple small-scale studies conducted in various regions of the nation confirm regional disparities and that MMR has not decreased over the past few years (Berhan & Berhan, 2014; CSA, 2012; Tessema et al., 2017). Studies confirm that the national target to achieve Millennium Development Goals (MGDs) related to MMR in the past two decades has not been met in Ethiopia (Tessema et al., 2017).

[23] FMOH. (2012). Maternal child health and nutrition: Maternal Health Case Team. Retrieved from http://www.moh.gov.et/maternal-and-child-health

The ministry's general strategy to address maternal health is a combination of services provided at the health post, health center and hospital level. Key maternal health interventions and strategies outlined by the federal ministry include the provision of skilled birth attendance in health facilities, family planning services, provision of quality basic and emergency obstetric care, maternal and newborn health care, strengthening the emergency obstetrics referral network and maternal death surveillance and response, elimination of obstetric fistula, safe abortion services and a pledge to see home-delivery free Kebeles[24]. The most recent HSDP has established a set of inter-related performance indicators to monitor the progress made in maternal health services. These include a measure of contraceptive acceptance rate (CAR) to trace women's use, antenatal care (ANC) as a measure of access and quality of care and detection of maternal risks to improve health outcomes for the mother and the new-born. In addition, "coverage of skilled care at birth and birth attendance by HEWs, as well as postnatal care (PNC) services" are stated as key elements of care (FMOH, 2015a, p.9). Priority strategies of the government are hence, the provision of family planning services and facility-based skilled delivery. This is also evident in the general key performance indicators outlined in the main policy document. One of the key performance indicators of the health sector as a whole is the reduction of MMR to 267 per 100,000 live births by the year 2015, by increasing contraceptive prevalence rates and skilled birth attendance.

The set targets and performance indicators in the documents demonstrate that maternal health services include both preventive and curative services. Hence, simply looking at the policy would indicate that, whether women's reproductive desire is to have

[24] Ibid

a pregnancy or prevent one, this desire is addressed in the Ethiopian Health Policy. Part of the research inquiry in this study was to investigate the policies and strategies underway. Remarkably, the current health policy and HSDP on paper seem comprehensive, including both preventive and curative maternal health services in their statements, strategies and performance indicators. Despite various global challenges to producing comprehensive health policy frameworks in many third world nations, the government of Ethiopia seems to have managed in the past 26 years to establish and clearly state all-encompassing maternal health strategies that seek to provide both preventive and curative care. This is a tremendous achievement and a step forward towards improving maternal health for Ethiopian women.

However, in order to have a holistic view, we also must assess how these policy statements are actually translated into action, investigating whether the policy strategies have actually benefited the women and men they were intended to support. In addition, we also need to look at how other policies and strategies pertinent to maternal and reproductive health such as the Reproductive Health Strategy (RH strategy) and the National Population Policy relate to the National Health Policy and impact maternal health outcomes.

Policy Paradox: Comprehensive Reproductive Health Service Vs. Population Control

The National Health Policy outlines the provision of family planning services and specifically contraceptive prevalence as a key national maternal health preventive care indicator. Article 35 section 8 of the constitution as mentioned earlier also specifically states the rights of women to "have access to education and information on family

planning and the capability to benefit thereby so as to protect their good health and prevent health hazards resulting from childbirth" (Federal Democratic Republic of Ethiopia [FDRE], 1994). I therefore, examine the various strategies and policies pertinent to family planning and fertility issues mainly from a policy perspective. Chapter four addresses women's experiences of family planning services in the specific Kebeles of the two regions. In addition to the National Health Policy, there are two major policy documents that address family planning and fertility issues in Ethiopia. These are the Reproductive Health Strategy document and the 1993 National Population Policy of Ethiopia.

Reproductive Health Strategy.

The Reproductive Health Strategy was designed on the one hand based on the international population and development frameworks outlined in the ICPD in 1994 and on the other on the MDGs (FMOH, 2006). The Reproductive Health Strategy document is an extension of the National Health Policy agenda and its primary objective is to enhance what is already being implemented by the health extension program with an exclusive focus on reproductive health concerns of the population. One of the main priorities of the strategy is to focus on the MDG goals of improving maternal health and promoting gender equality. A National Reproductive Health Task Force was responsible for setting reproductive health goals, agendas and the design of the strategy document. The task force is comprised of various participants including local government sector representatives, technical experts, NGOs and international reproductive health organizations.

On the surface, the RH strategy seems like a comprehensive document stating the need to take into account underlying socioeconomic and demographic realities of the population that impact reproductive health in the process of achieving international development goals such as the MDGs (FMOH, 2006, p.viii). Beyond what the national health policy and the HSDP address, the strategy highlights social and institutional contexts of women's health before setting targets and suggesting possible solutions. The documents state that "Women's health is directly affected by the social and institutional context in which they live. Issues such as their low socioeconomic status, HTPs, especially FGC, early marriage, and low female literacy, all have a direct negative impact on women's health. The issues and strategies outlined below affect and cross-cut all aspects of RH, extending well beyond what can be addressed by the health sector alone. The success of efforts to improve the RH of all Ethiopians hinges on the removal of these constraints" (FMOH, 2006; p.8). The government and partners' effort to address social and institutional factors of reproductive health at large and maternal health, in particular, is noteworthy. These statements create the impression of a social justice oriented approach to reproductive health. The strategy clearly explains various socio-cultural and economic challenges women face in achieving reproductive health.

However, the actual targets set to address maternal health, fertility and family planning issues are inconsistent with the holistic reproductive justice approach outlined in the strategy. The targets set have subtle population control narratives worth examining. Fertility and family planning are one of the major focus areas addressed in the RH strategy. The strategy notes that Ethiopia is the second most populous African nation. The RH strategy attributes Ethiopia’s high fertility rate to traditional values and desires of

having large number of children, high infant mortality, early marriage, socio-economic status of women and the agricultural basis of the Ethiopian society and the subsistence way of life that requires children as a source of labor and support (FMOH, 2006).

These explanations resonate with the women and community members I have interviewed in the Kebeles of the two regions and with women in many third world nations who have high fertility rates (Chen 2011; Hartmann, 1995; see also Chapter Four). However, the solutions suggested in the strategy tend not to match or remedy the reasons and circumstances discussed. The strategy focuses mainly on increasing contraceptive prevalence rates and educating women and their families about the need to limit their fertility. Having a large number of children is regarded as a constraint and a harmful tradition that needs to be limited or done away with at all costs. The strategy solutions do not address the economic factors of subsistence life where children are needed as a source of labor. They also do not take into account the cultural prestige and values attached to having children in the Ethiopian society. These socio-economic conditions do not get resolved by simply educating women and providing them with contraceptives.

The strategy states that "low educational attainment further perpetuates high fertility, as these women [rural women] tend to have less knowledge of and access to FP [family planning] options" (FMOH, 2006, p.12). Women's misinformation and misconception about family planning are also discussed as reasons for not utilizing FP services. The strategy document also links recent decline in average fertility rate to increased contraceptive prevalence, increased awareness of family planning services and the education of women. Many studies including the ones the strategy is based on assert

that there is a direct correlation between educational status and fertility. They also state that fertility rates are high in rural areas where the majority of the population reside and do not attend formal education (Alemayehu et al., 2010; Ayele, 2015; CSA, 2012). Hence, sending women and girls to school is one of the solutions presented in the strategy in order to limit fertility and address reproductive and maternal health issues. This might seem like a "logical" solution since girls will ideally delay marriage to attend school and might avoid the maternal complications that result from early childbearing. However, what is not taken into account here is whether the cultural desire to have children will diminish and whether the rural subsistence living that many children are needed for will be addressed by simply sending women and girls to school. Hence, the actual reason why rural communities decide to have many children remains unaddressed. Other studies have made similar analyses to demonstrate the ways in which development discourses of educating rural women and girls to prevent pregnancy or to improve livelihood has not considered the socio-cultural and economic contexts in which the women and girls reside (Chant, 2016; Switzer, 2013).

There are modernization and development narratives in the family planning and population control approach the Reproductive Health Strategy is employing. The strategy claims that women and their communities lack the knowledge or are unaware of ways to limit their fertility. Traditional birth spacing methods are not considered knowledge at all. Breast-feeding and other pregnancy prevention cultural practices are not mentioned as pre-existing ways women had used to limit their fertility for centuries when they desired to do so. This modernization narrative creates rural Ethiopian women as ignorant subjects needing to be controlled by the state. This undermines women's ability to control their

fertility and simply assumes that women do not know about fertility control and family planning services. However, in the interviews I had in both Kebeles, women were very much aware of the existence of modern family planning services but were hesitant to use them. Hence, overarching narratives that women are unaware of family planning services need to completely change in order to design appropriate interventions addressing women's desires and their refusal to use modern family planning methods.

National Population Policy.

The other policy pertinent to maternal health, fertility and family planning is the National Population Policy. The policy highlights the social and economic environment of Ethiopia and arrives at the conclusion that demographic challenges and development shape one another and that "high fertility and rapid population growth exert negative influences on economic and social development and low levels of economic and social development provide the climate favoring high fertility and hence rapid population growth" (FDRE, 1993, Section 3, papa. 2). This would seem like a neutral conclusion. However, the policy's strategies to address population issues clearly depict the government's inclination to address the former. The policy asserts that significant reduction in population growth will result in the country's achievement of social and economic development and that this will ease the future burden of demand for resources (FDRE, 1993).

Ideas of population control are more overt in the National Population Policy when compared to the Reproductive Health Strategy document. Similar to Neo-Malthusians' claims about population and the environment in Hartmann's discussion of population control, the Ethiopian Population Policy defines population growth as a threat to the

environment resulting in a shortage of resources and burden in the earth's ability to provide for an ever-growing population (Hartmann, 1995). Consequently, the objectives and specific strategies outlined in the policy to address population issues, fertility, family planning and overall maternal health include: planned reduction of population growth and increasing economic returns; reducing the current total fertility rate; increasing the prevalence of contraceptive use and significantly increasing female participation at all levels of the educational system; improving the economic and social status of women and reducing maternal, infant and child morbidity and mortality rates (FDRE, 1993, section 4. objectives and strategies).

Similar to the RH strategy, the primary goal of the policy is to limit fertility and stop most pregnancies from occurring. Women's productive engagement in their communities and educational system is indeed a positive outcome to work for. However, underlying development modernization assumptions about sending "uninformed" women and girls to school present in the reproductive health strategy document are also pervasive in the Population Policy objectives. Even though these national policy documents specifically address reproductive health, fertility and population issues, they do not mention the reproductive desires and needs of women and men in the policy but only focus on strategies to limit them. According to the most recent Demographic and Health Survey (DHS), more than half of currently married women in Ethiopia aged 15-49 (57 percent) stated that they still want more children. However, 38 percent stated that they want to wait for two years or more before having their next child (CSA, 2012). Surely there is room in these two ostensibly contradictory findings for the creation of a flexible, responsive maternal health policy that adequately reflects Ethiopian women’s

fertility interests and desires while providing the means (both traditional and modern) to those who wish to space and/or limit their birth. However, the current RH strategy and the population policy primarily focus on limiting fertility and increasing contraceptive prevalence without due regard to other socio-economic factors. The same survey states that 37 percent of currently married women age 15-49 and 29 percent of men want no more children or are sterilized (CSA, 2012). Whether this sterilization is based on informed consent or not, the cultural context in which it occurs (where children are a source of labor and social security), and the condition under which sterilizations are conducted need further investigation.

Overall the National RH Strategy document, although not entirely favorable, seems a bit more holistic in its approach compared to the Population Policy. The National Population Policy is not up-to-date in terms of the recent, global post-ICPD reproductive health dialogue regarding context-specific issues and it has not been revised so far. Interestingly, there is a statement in the RH strategy urging the Population Policy to be more comprehensive and to broaden its view beyond population control frameworks: "The National Population Policy should be integrated with the National RH Strategy, reaffirming the policy, while broadening its attention to post-ICPD concepts of RH" (FMOH,2006, p. 12). Nevertheless, both policy documents are marked by population control narratives seeking to primarily provide family planning services to address reproductive and maternal health issues.

The analysis of the National Health Policy, the Reproductive Health Strategy and the National Population Policy paints a picture marked with inconsistencies of government pledges to provide comprehensive maternal health care (in the case of the

National Health Policy) and its prioritization of fertility control over the reproductive desires and needs of women and other maternal health services (in the case of the RH Strategy and the National Population Policy). The inconsistencies found in the documents are also evident in the actual implementation of maternal health and family planning services. Consequently, either due to policy or financial reasons family planning services are widely available at the health posts in the regions while basic and essential emergency obstetric care are nonexistent.

Cost of Maternal Health Care and the Government's Push Back Against Global Economic Pressure

Another significant aspect of policy implementation that needs careful examination is the cost of maternal health care. Health expenditure in Ethiopia, both public and private, is very low (ADF, 1997). So far the country can only afford to spend less than 5.1% of the overall government annual budget on its health services (FMOH, 2015a). Given the level of poverty Ethiopia is facing and the global economic pressure to pay debts and reduce foreign aid, the country is struggling to provide basic health care services to its growing population (Sachs, 2001).

The Ethiopian health finance reform is one of the SAPs underway. Until recently the program had significantly raised medical costs incurred by pregnant women seeking to deliver in health facilities. The reform was initiated and implemented in Amhara, Oromia, and Southern Nations, Nationalities, and People (SNNP) Regional States (Zelelew, 2012). The reform was strategized based on the generation and retention of revenue through the establishment of user fees, outsourcing non-clinical services, partially privatizing public hospitals and systematizing fee-waivers for the poor. In

addition, the government is working to establish community-based health insurance for informal sectors and social health insurance for the formal sectors (Ibid). Studies in the past few years demonstrate challenges caused by the financial reform (Sipsma et al., 2013; Zelelew, 2012). The burden of health cost has largely fallen on the population, resulting in poor and low-quality health services and the inability to seek these services. Even though fee-waivers were technically there for the poor, "fee waiver certificates to the poor as verified through local social justice systems at the time of sickness resulted in cumbersome procedures that caused delays in the poor's ability to access care" (Zelelew, 2012, p.4). Sipsma et al. (2013) pointed out that medical costs were among the major reasons Ethiopian women were discouraged from visiting health facilities or delivering there.

As a result of the health financing SAP, currently the majority of the finance for health care (58%) is covered by households (the people) and the government (37% and 21% respectively) followed by the foreign donors (40%) and the rest 2% comes from employers (WHO, 2014a). Even though the government manages most of the health spending, it faces grave challenges when it comes to flexibly allocating resources that come from donors which are ear-marked for specific health services (WHO, 2014a). As stated earlier in the ministry's strategic documents and as explained by the health officials, the government has employed the SWAP framework and established joint coordinating committees with major donors for effective aid management. This was done to strategize pooled funding and to ease both the burden of managing these fragmented resources and to find some flexibility in the decisions to allocate funds to policy priority

areas. However, program results point towards the challenges in financial resources (FMOH, 2015).

As noted above the last demographic and health survey (DHS) conducted in the past five years and other data sources highlighted more or less stagnant maternal mortality rates and the delay in reducing them (Berhan & Berhan, 2014; CSA, 2012). As a result, the government made a policy shift in health financing in an effort to reduce mortality rates in the country and to achieve MDG goals by 2015 (FMOH, 2010). In the past five years, the government made an effort to provide comprehensive obstetric care and address maternal health concerns as shown in the overall National Health Policy through financial commitments to make maternal health services cost-free.

Financial strategies outlined in the last HSDP (IV) show the effort to increase the health budget to that effect. Maternal health accounts for only 7% of the national health budget of the nation among other core functions. The government planned to mobilize additional funds to reduce mortality rates and improve health services in the health extension program with a base case and best case scenarios. Specific costing targets for maternal health were set in HSDP IV with an increase in funds by 11.96 dollars per capita annually resulting in a 54.8 % reduction of maternal mortality rates or an increase in funds by 13.96 dollars per capita per annum resulting in a 56.6% decrease with base case and best case scenarios respectively (FMOH, 2010). In addition, the government established the MDG performance fund that became effective during HSDP III. The MDG performance fund is a fund established by the ministry to fill the financial gap in the health system including maternal health, overall health service delivery and medicines, commodities and equipment (FMOH, 2010). The establishment of such fund

is a remarkable resource mobilization effort by the government to fill budget gaps and address maternal health issues. It also points to how poor third world governments realign their policies and financial strategies with global pledges in order to obtain funding and support from outside sources.

In 2012 the government initiated accelerated programs to achieve maternal health MDGs by 2015. Key informant health officials at the federal ministry and Woreda health offices also confirmed the special emphasis given to maternal health since 2012. Major interventions underway include cost-free delivery, provision of one or two ambulances per Woreda specifically for delivering mothers and the construction of maternity waiting rooms that rural women and their families coming from remote areas can utilize for a few days before or after delivery. The government has also made significant strides in the construction of health facilities in almost every Woreda and Kebele as part of the health service coverage effort underway. The annual performance report of 2015 states that so far a total of 16,447 health posts have been constructed throughout the nation and a total of 3547 functional health centers and 234 hospitals of which 147 are fully functional. This is in comparison to a nation that had a total of 89 hospitals, 160 health centers and 2292 health stations in 1990 (Kitaw et al. 2012, FMOH, 2015a). This is a relatively significant improvement given the limited amount of resources the nation spends on overall health due to SAPs and other economic circumstances.

When we see the actual implementation of these interventions, women and men have noted that ambulances and cost-free delivery services have also been operational in both of the regions and specific Woredas and Kebeles I have visited. Currently, pregnant women can deliver in health facilities absolutely cost-free. One ambulance is stationed in

each of the Woredas. Some women from both regions have affirmed that they or their neighbors have used these services. Availability of one or two ambulances per Woreda is relatively a step forward from having none. In remote Woredas with rough terrain, having an off-road ambulance significantly reduces the time it takes to get to the health facility and improves the chances of transporting pregnant women safely compared to manually carried stretchers. In some places, the community has also been involved in mobilizing funds for ambulances. Community members in the focus group discussions and some women in Mecha Woreda have explained the sense of ownership and confidence they felt in acquiring the ambulance in their Woreda. Also, according to the 2016 performance report, the community in Amhara and Oromia contributed 115 million birrs in Oromia and 74 million birrs in Amhara which resulted in the additional procurement of ambulances (FMOH, 2016).

Despite the government's effort to mobilize funds from various sources, lack of adequate financial resource remains a major challenge. The 2015 annual performance report and interviews with health care officials both highlight a lack of financial resources (FMOH, 2015a). This has resulted in fewer health facilities being built and fewer health professionals being trained and deployed. There is also an uneven distribution of resources in terms of covering costs of delivery, medical equipment and ambulatory services across regions and rural-urban geographic locations (FMOH, 2015a). The current health facilities, most of which are not adequately staffed and equipped, are expected to serve a total of 94 million people, close to double the population in the 1990s (50.8 million) (Kitaw et al., 2012; Shiferaw et al., 2013; Sipsma et al., 2013). The government still has a long way to go in terms of building health facilities and providing

adequate health care for its population. The figures stated in the annual performance report show both regional and rural-urban disparities in the development of health infrastructure. Moreover, most of the health centers and hospitals which provide basic and emergency health services are located in semi-urban and urban cities and towns far from the majority of the population (FMOH, 2015a).

In addition, one ambulance per Woreda is hardly adequate to meet the needs of large Woredas such as Mecha with 370,000[25] people and Seden Sodo with 170,000 people, of whom half are women (CSA, 2012). Maternity rooms are also not yet available in many health facilities across the nation and specifically, in the places I have visited. Hence women traveling from remote areas still face challenges in accessing health services. The government requires additional funds to successfully service the population.

Another problem that women highlighted in the interviews is that the cost of care is free only in times of delivery. Hence, antenatal and postnatal visits, and other maternal health services including emergencies prior or after delivery may cost women transportation and health service fees. Researchers have shown the significance of prenatal and postnatal visits in saving the lives of women (Koblinsky, 2003; Shiferaw et al., 2013). However, women in Mecha and Seden Sodo explained the challenges of seeking health services before and after delivery. A woman in Mecha Woreda explains as follows:

> Most women do not go to the health facility for checkups before or after they deliver. It is simply tiring, time consuming and unaffordable. We do not have time to travel that far, and we cannot afford the transport. The ambulances are only there for delivery and in times of emergencies. If we have an emergency during delivery, then we will call the ambulance. (Interview, Amhara, Mecha)

[25] The statistics were taken from Mecha Woreda Health Bureau.

Ideally building health facilities and enhancing the health infrastructure improves women's access in times of emergency. In addition, antenatal and postnatal care services provide rural pregnant women with early detection of complications in case of emergencies. However, such type of access is not yet a reality for many rural Ethiopian women. The government requires additional financial resources to make these services available for women beyond making costs free for delivery emergencies.

Studies affirm the lack of medical equipment and human resources in many health facilities in the rural areas and the fact that most health facilities are far from where communities reside (Sipsma et al. ,2013; Shiferaw et al., 2013). HSDP IV and the 2015 annual performance report from the government also confirm the gaps in implementation such as the absence of 24 hours and seven days a week services in most health facilities especially in health centers (FMOH, 2010, 2015a). The health infrastructure and access challenges can be attributed to the lack of financial resources to make maternal health care available and closer to women. As noted earlier many Amhara and Oromo women I have interviewed have stated that they have never gone for antenatal and postnatal check-ups since the health facilities are very far. Some in both regions mentioned that it takes 2-3 hours on foot to get to the nearest health post and 4-6 hours on average to access the nearest health center. They stated that the trip to and from the health center would be draining given that they have their daily activities to attend to (see also chapter four).

The nation's attempt to provide community-based and equity-oriented maternal health services despite the lack of financial resources and the pressure to privatize is noteworthy. The health ministry's interventions in the past few years to keep delivery costs free for pregnant women and the provision of ambulatory services, however

minimal, is evidence of the effort underway to reduce national maternal mortality rates. The effort to mobilize financial resources and the use of MDG funds attests to both the constraints of development health care privatization and reform, and the opportunities poor governments create using development frameworks such as MDGs to address maternal health issues. In resource-poor countries funding is largely dependent on donors and their economic and political interests. Hence being creative and determined about mobilizing resources and policy priorities the nation intends to pursue is not an easy task in the context of structural adjustments and market-oriented development. Currently, maternal health remains one of the priority areas in the health policy, and yet it lacks financial resources needed to make significant progress. This impedes the government's effort and hinders many women who seek these services.

Apart from the priorities outlined in the Reproductive Health Strategy and Population Policy discussed above the other reason for the primary focus on "preventive measures" such as family planning to address maternal health concerns could be in part due to the nation's lack of financial resources for basic and emergency obstetric care. Family planning services are cost effective compared to full-ranging obstetric care (Petchesky, 2003). Family planning is widely available and free in all health posts in both regions and Woredas while maternal health services are non-existent. International donor agencies and non-governmental organizations freely donate contraceptive pills, injections and implants to many third world nations and Ethiopia is no exception (Takeshita, 2012). Both Oromo and Amhara region participants repeatedly noted the wide availability of free family planning services and remarked that health care professionals consistently educate, encourage and in some cases urge them to utilize these services. Also based on

my observations when visiting the health posts in both Andenet Kebele in Amhara region and Mudena Ibbayyuu Kebele in Oromia, the primary activity that health extension workers carry out in addition to the first aid services they provide is family planning service.

Local Innovative and Gender Sensitive Maternal Health Strategies and Gaps

Ethiopia is among the nations that are facing critical shortages of health professionals with one physician, two nurses and medical midwives, one pharmaceutical personnel, one environmental health worker, one public health worker, three community health workers and two hospital beds per 10,000 people (Prata et al., 2011; WHO, 2014b). The shortage is unevenly distributed between urban and rural areas, with more than 84% of the population living in the rural area and most physicians and nurses being heavily concentrated in the urban areas (Ibid). The 2015 annual performance report shows that "3,117 new medical students were enrolled in 27 public medical schools in EFY 2007, making the total medical students on training 14,940. The physician to population ratio improved from one physician per 20,970 populations in EFY (Ethiopian Fiscal Year) 2006/2014 to 1 per 17,160 populations in EFY 2007/2015" (FMOH, 2015a, p.10). This is a relatively improved figure in comparison to previous years, but as one can imagine a physician to population ratio of 1-17,160 is still very high. There are currently 304 obstetricians and gynecologists for the entire nation registered with the Ethiopian Society of Obstetricians and Gynecologists (ESOG). They are expected to serve more than 90 million people and most of them work in urban areas. Similarly, nurses and medical midwives are still in great shortage. So far a total of 9000 medical midwives have graduated to serve the entire population.

Moreover, numerous Ethiopian health care professionals, specifically nurses and doctors, leave home to serve wealthy western and Arab nations mainly in North America, Europe, Qatar and Saudi Arabia as a result of globalization and trade agreements (Semela, 2011; Shinn, 2002). Shinn (2002) notes that the brain drain of Ethiopia is very high. For example, out of 2491 general practitioners trained between 1988 and 2001, the country has lost one-third to North America, Europe and South Africa. Even though recent data are unavailable on the migration of skilled health professionals, there is evidence that suggests that the brain drain has intensified (Semela, 2011). The government has recently established laws that will urge doctors to serve at least two years of residency in remote rural areas prior to obtaining their license and degrees.[26] However, agencies and health institutions from different Arab nations, for instance, Qatar in particular, hire Ethiopian doctors without credentials simply based on government university graduation yearbook photos.[27] This is one indication of the challenges poor third world governments encounter in mediating global trade demands for their skilled professionals and the provision of health services to their citizens (Grown et al., 2006). Despite a lot of resources spent on training each health professional, poor rural women in Ethiopia still do not get the services that they desperately need.

Health Extension Workers (HEWs)

In the absence of health professionals such as doctors, nurses and midwives, the government has devised two major innovative local strategies to expand health services and make health information, education and care available to the community. The

[26] Before joining any government medical faculty, college students will sign forms agreeing to serve 2-4 years before obtaining their official degree.
[27] Personal encounters with physician at Addis Ababa University, Medical Faculty.

strategies are the training and recruitment of Health Extension Workers (HEWs) and the recent organization and deployment of Health Development Armies (HDAs) to reach rural and underserved communities. HEWs are young women, high school graduates selected from the community (2 from each Kebele) that provide health information, education and primary health care services. HEWs are trained for one year to provide preventive and curative health services on sixteen health extension package programs with basic components such as "hygiene and environmental sanitation; family health services; disease prevention and control; and health education and communication " (FMOH,2010). Under the family health services package HEWs are trained on the provision of maternal health services (FMOH, 2010). Even though HEWs are stationed at the health posts, 75 % of their work includes going house to house providing health information and education and referring or assisting pregnant women with antenatal, postnatal and delivery services (Koblinsky et al., 2010). In addition, many women who are seeking reproductive and maternal health care services such as family planning, antenatal and postnatal check-ups can easily access these services through referrals from the HEWs. The government has succeeded in graduating and deploying a total of 34,382 health extension workers in the past decade (FMOH, 2015a).

This local initiative is groundbreaking since it achieved the national health policy objective of engaging young community members in the health service delivery process. Hence, it confirms the government's political will to provide community-centered health services. In addition, in a country where the majority of the government sector jobs are taken by men, the fact that women are specifically targeted for these job opportunities is a breakthrough in the history of the Ethiopian health system. The program's focus on

women as health care providers and their empowerment through health training and employment make it a remarkable, gender-sensitive approach of the health sector. From the discussions I have had with health extension workers in both regions, the young women feel empowered with a job to sustain them. In addition, the fact that HEWs are recruited from the Kebele they live in makes getting around and acclimatizing themselves with the environment, the terrain, mode of transport, the language and the overall culture easier for them compared to someone who would come from an urban area or even from a neighboring Kebele. A health extension worker from the Oromia region explained her experience as follows:

> I am happy that I get to work with women in my area. I also have a young one at home, so this job is the main source of income for us. In addition, I was able to easily ask for a transfer from another Kebele to this one to be close to my family because I am from here. I like the fact that I get to live and work in a place where I grew up. (Interview, HEW, Oromia, Seden Sodo)

However, health extension workers face various challenges on the job. Lack of proper training and resources in the health posts are among the major challenges HEWs face. With no medical equipment in the health posts and inadequate delivery skills HEWs have not been able to assist women in child delivery. In an effort to address this gap health extension workers in almost all the regions recently received an accelerated skill upgrading training to handle clean and safe delivery at the health post and at home. They have also been informed to immediately refer pregnant women to the health centers after the deployment of ambulances in every Woreda (FMOH, 2009; FMOH, 2015). However, the delivery training that the HEWs receive is a maximum of one to three months, leaving

HEWs with inadequate training and lack of confidence in their skills. A health extension worker from Oromia explains her experience as follows:

> My first experience in assisting delivery was at the training at *Tulu Bollo* Health Center in 2003 EFY (Ethiopian Fiscal Year) [2012]. The experienced Nurse Midwife was guiding me. After wearing the gloves, when my hands came into contact with the head of the baby, I experienced a shock as if I touched a snake and almost dropped it. However, with the stern reprimand and help of the nurse, I was able to do the first delivery. I was also frightened to cut the placenta. After my training, I have assisted 3 deliveries in the past four years. One was at home and 2 in our Health Post with my colleague. I am afraid to deliver babies, especially on my own. (Interview, HEW, Oromia, Seden Sodo)

The HEW's response clearly points to her fear and inexperience of delivery. The HEW was only able to assist three deliveries in a Kebele that has many women in their reproductive age. Quality and length of training have a lot to do with acquiring the proper skills and gaining experience (Damtew et al., 2012). A three-month training is hardly sufficient to obtain such skills or experience. The other reason for their lack of experience is that women are not utilizing their services. According to the annual performance report for the year 2015, the percentage of deliveries attended by HEWs nationally fell to 3.9 % from a baseline of 8.8%. While the report claims that an increase in skilled birth attendance in health centers/hospitals and referrals by HEWs have resulted in the percentage drops of delivers attended by HEWs, there is some evidence that would suggest otherwise. According to other small and large scale studies the number of deliveries attended by skilled birth attendants, despite what the government data estimates (60%), is very low with regional and rural-urban disparities (Alemayehu & Mekonnen, 2015; Berhan & Berhan, 2014). For the past decade Oromia and Amhara regions, following the pastoralist regions, have had the lowest performance in skilled

delivery (FMOH, 2015a). Therefore, if women are not delivering in hospitals and health centers with skilled birth attendants or at the health posts with the help of HEWs, then this would suggest that many of them are delivering at home. Then one would have to ask why women are not going to HEWs for delivery and why the numbers of deliveries have dropped. This leads us to another challenge HEWs face in the rural communities they serve.

While gender and the level of education are the basic criteria for the selection and training of HEWs, various other socio-cultural factors have not been properly considered. For instance, age and the value given to older community members has not been taken into account in training young women to address maternal health. The probability of being taken seriously in the community for young female health extension workers is often far less compared to men and older women. Hence, while the HEW strategy is gender sensitive, it lacks age and cultural context. An HEW explains issues of respectability and being heard in the community as follows:

> They [women] hear what we communicate but the problem is they do not often put it into practice… and there are many who do not accept what we offer. Some say they will eventually take family planning and do not want to be rushed [in an effort to stall] but I know that some are following up the traditional practice "*Amechissa*"[28] to deliver at home. Some also take the child to fortunetellers who "bless" the child and name him.

It appears that even though women in the community listen to HEWs or invite them into their homes, they do not take the information seriously. Some studies in recent years have documented similar patterns where HEWs are often faced with the challenge

[28] *Amechissa* encompasses Oromo traditional practices of birth, including birth spacing, child delivery, child blessing and fortune telling.

of trying to convince women to take up family planning or skilled delivery and other maternal and reproductive health services (FMOH, 2009; Kok et al., 2015). Both my focus group discussions and interviews in the two regions confirmed that age and experience of HEWs has a lot to do with the acceptance problems they face in the community. In reference to maternal health, the majority of the interview participants from both regions, including the health extension workers themselves, stated that older women such as Traditional Birth Attendants (TBAs) are still held in high regard in the community.

The World Health Organization defines a TBA as "a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs" (WHO, 1992, p.18).[29] TBAs are often older women who have not had any formal medical training or education. They are highly respected due to their knowledge of maternal and child health compared to young and mostly inexperienced health extension workers. In addition, women have also mentioned unavailability of HEWs on weekends and at night in contrast to TBAs who are often neighbors or relatives willing to assist at any time of the day. The above findings resonate with the studies in many sub-Saharan African nations where the majority of the pregnancies are attended by TBAs (Choguya, 2013). TBAs and the value of traditional knowledge will be further discussed in the following section. Despite the policy statements demonstrating a willingness to integrate traditional and modern medicine and

[29]World Health Organization (WHO). (1992). Traditional birth attendants: a joint WHO/UNFPA/UNICEF statement. Geneva: World Health Organization.

practice in the previous health policies and in the current one, health professionals' perceptions of TBAs and their attitudes towards their practices are not progressive.

Policy challenges outlined in the 2015 annual performance report and the discussions I have had with Woreda health professionals and heads from both regions note that there is high employee turnover and a shortage of HEWs in many Kebeles (FMOH, 2015a). A health extension worker mentioned that lower salary, lack of promotion opportunities and substantial training demotivate HEWs. The HEW in Amhara explained the situation as follows:

> I recently came to Andenet Kebele. The previous health extension worker had left. I am the third one to be replaced in this area. HEWs leave because there is no training or skills upgrading that will allow us to be promoted, so many are discouraged to continue as health extension workers. (Interview, Andenet, Amhara)

Overall the deployment of HEWs in the community has had a mixed impact on women's maternal health experiences. As mentioned earlier the job opportunity created is commendable and the fact that rural women can access reproductive health services such as family planning information and education from HEWs, and referrals in times of emergencies marks a significance progress in the health delivery process. However, socio-cultural context, training and quality of service delivery need further attention to strengthen the service HEWs provide to the community. Policy makers and health care professionals need to ask why women are not utilizing delivery services provided by HEWs before simply assuming that women are moving up the referral ladder to the health centers or hospitals to skilled birth attendants.

The Health Development Armies (HDAs)

The deployment of Health Development Armies (HAD)s is the second strategy the government employs to strengthen the health extension program and to engage the community in health service utilization. HDAs are women development groups comprised of 30 women in 5 small networked groups each having six women. These six women are in a one-to-five network with one woman supervising and reporting on their activities. The women are trained by the health extension workers on key health packages including hygiene and sanitation, maternal and child health, environment, etc. The primary focus of HDAs is on improving health in their households and neighborhoods (FMOH, 2015). The strategy includes raising awareness and mobilizing the neighborhood to access health services, promoting healthy behavior and best practices through "model" families that others will emulate and holding community dialogue sessions with the guidance of the HEWs (Ibid). Monitoring and reporting the number of pregnant women to the health professionals and Kebele officials in the area is also a key maternal health activity in these groups.

This development strategy is the government's effort to establish a community-owned and women-centered health system. Again similar to the deployment of HEWs, this is a commendable gender-sensitive effort in terms of how it seeks to engage women in health service provision. In addition, HDAs in many areas are utilizing traditional social spaces such as the coffee ceremonies to discuss health issues. Since coffee is mostly a "women only" social space that many rural women engage in, it is convenient to reach women and discuss important health issues. This type of activity where women are engaged during their free time and in the space where they are comfortable makes this

strategy a unique one. Moreover, fund mobilization for ambulances and the construction of maternity waiting rooms in some areas is promoted and organized by HDAs (FMOH, 2016).

The government claims that HDA strategy has been implemented in many areas in all the regions of the nation. According to the recent performance reports, so far 317,309 women development groups have been created in Amhara and Oromia regions alone (FMOH, 2015a; FMOH, 2016). The 2015 performance report states that these women development groups have resulted in increased skilled birth attendance and necessary follow-up for pregnant women (Ibid). The report also notes that the HDAs call ambulances for pregnant women in times of emergencies.

However, from my observation and discussion with Woreda health officials, there are disparities within the regions in terms of the number and availability of these groups. The women in the Kebeles I have visited in both regions, for example, had different experiences. In Andenet Kebele in Amhara region these groups have been created and are currently active, working with women in their vicinity. One of the focus group discussants in Amhara was an HDA member. Conversely, in Seden Sodo Woreda of Oromia, all of the women that I interviewed stated that they are not aware of these groups and have never heard of HDAs. Hence it is safe to say that HDAs are not active everywhere. The Oromia Woreda health office head explained the situation as follows:

> The program was launched in EFY 2004/ 2012. The aim was to empower women and create conditions where they get organized and conduct monthly meetings to exchange experiences and get better awareness on maternal health and other health concerns. However, the performance in this regard has not been successful in our Kebeles. HDAs are not active in our Kebeles and they are not functioning as expected. There is a gap in this regard. There are some HEWs that

> make an effort to mobilize women but they have not been successful. This is partly due to shortage of HEWs in most Kebeles. (Key Informant Interview, Amhara)

Even though it is a challenge to mobilize women when there is a shortage of HEWs, this also shows the community's hesitation to actively engage in these organizations. Therefore, it is crucial to find out why women are not active in HDAs. According to the interviews with women in the community and my observations, the organizational setup, political power and hierarchy are among the reasons why some communities may be reluctant to organize in HDA networks. The organizational set up (one-to-five networking), monitoring and reporting mechanisms designed to surveil the community and their neighborhoods are similar to what the government, specifically the ruling party, employs to promote its political agendas. Judging by my observations, the interviews and focus group discussions, communities are skeptical and fearful to openly share their opinion in such groups. In many cases, women stated that supervisors in the HDAs one-to-five networks are also appointed from the ruling party. Consequently, there is bias and fear in the community about engaging in the HDAs. Some of the women I have interviewed in the Amhara region stated that the HDA supervisor in that Kebele is a member of the ruling party. These groups and the purpose they serve in the community should be free from any political bias in order to genuinely and equally engage all community members.

Overall, both the HEW and HDA interventions are gender sensitive and women-centered approaches to address maternal health issues. They are noteworthy for the opportunities they have created for thousands of women to engage in the health service provision of the nation. However, the implementation challenges have compelled me to

ask why women are hesitant to engage in and obtain services from these community-based initiatives.

I contend that the maternal health service provision and the dissemination of reproductive health knowledge through these strategies are based on some underlying development and modernization assumptions and narratives that require further dialogue and investigation. The following sections examine such assumptions and knowledge gaps in policy formulation that have created an impasse between the policy and the reproductive health desires and needs of women and their communities.

Local Development Narratives, Knowledge Constructions and Policy Gaps

I have observed development and modernization narratives and assumptions underlying maternal health policy statements and strategies in both the documents, and in my interactions with health officials and health professionals. Critically, these assumptions determine the type of maternal health services that are currently being provided. First, even though the health policy states that a community-centered approach is pivotal, the state's health ministry, its health care professionals and health officials seem to assume that they know what is best for the wellbeing of pregnant women. Hence, the strategies to address maternal health issues are often top-down. Family planning policies and interventions, and the social acceptance issues faced by the community-centered initiatives of HEWs and HDAs confirm that the intervention ideas have come from the policy room and not from women and their communities.

Consequently, policy strategies only focus on a medicalized intervention in a nation where close to 80% of the population still rely on traditional health practices at home as primary care before seeking facility-based health services (Kassaye et al., 2006;

Mehari et al. 2012). Despite the shortage of health care professionals and lack of financial resources, the state still insists exclusively on the medicalization of maternal health care. However, the majority of women in Ethiopia are still unable or unwilling to deliver in a health facility even though the government prioritizes skilled birth attendance (Alemayehu & Mekonnen, 2015; FMOH, 2010; Shiferaw, 2013; Roro et al., 2014). Many studies, including this one, show that the majority of the communities in Ethiopia continue to use traditional health practices despite the push for medical solutions and health facility-based interventions in maternal health (Kassaye et al., 2006; Mehari et al. 2012; Getahun and Balcha; 2012). This creates a policy gap that requires further investigation. In countries like Brazil, over-medicalization of childbirth has led to stagnant rates in maternal mortality statistics (Diniz, 2012). In addition, as mentioned earlier when childbirth is medicalized, women's traditional reproductive health knowledge and childbirth practices are devalued. Traditional midwives were replaced by male physicians and medical technologies (Prosen, 2014; Roberts, 1997).

Similarly, the health ministry, health institutions and health professionals of Ethiopia are primarily concerned with medical solutions promoting zero home delivery and prioritizing skilled birth attendance in a health facility. The health professionals and institutions assume to know more about the reproductive health needs and desires of women including where and when they need to or should give birth than the women they serve. This is with a backdrop of the majority of Ethiopian women who continue to deliver at home.

Various biomedical and government studies claim women's "lack of knowledge" and information as one of the major reasons why women still prefer to deliver at home

(FMOH, 2010, 2015, 2016; CSA, 2012). However, similar to the experiences of many women in other third world countries like Bangladesh and Laos, my interviews and focus group discussions with women about their knowledge regarding facility-based health services and whether or not they are making informed decisions provide a different view (Sychareun et al., 2012; Sarker et al., 2016). Some Amhara and Oromia women pointed out that most of them are cognizant of the health services available in their areas but simply choose to deliver at home for other reasons including social support and comfort, feeling that childbirth is a natural, non-medical, non-pathological process or due to financial reasons. Hence, the overall assumption that most rural women lack knowledge is counter to in-depth small-scale studies such as this one, that suggest otherwise (Shiferaw et al., 2013; Sipsma et al., 2013). A discussion with a health official in the ministry about the development of maternal health policies and strategies highlights this prevalent underlying assumption.

> The fact is that medical interventions and delivery in health facility is the best option for women. Rural women typically lack the education and knowledge to make informed decisions. The government has come up with the best solution of mobilizing the community to seek health services. This is what has been done elsewhere. (Key informant Interview, FMOH, Addis Ababa)

This response confirms the assumption that the state knows what is best for women and their community and women are assumed to lack reproductive health knowledge. This constructs women and their community as "ignorant passive recipients" and as lacking RH knowledge that the state needs to guide and protect. Hobart (2002) in his discussion of western knowledge and international development asserts that in local knowledges of healing the patient is an active participant involved in the diagnosis and

the cure, “by contrast, scientific knowledge [claims] as observed in development practice generally represents the superior knowing expert as agent and the people being developed as ignorant passive recipients or objects of this knowledge” (Hobart, 2002, p 4).

Many local Ethiopian “health experts” and officials seem to have internalized development and medical discourses and assert that medicalization of maternal health is the sole option. Hence, they are the only knowing subjects whereas rural Ethiopian women and their communities are passive recipients and objects of this form of knowledge. This perspective conflicts with the idea of centering the community’s needs and interests in health service provision. While the government has the political will and interest to provide community-centered health services, instruments and strategies devised to make this a reality deny women’s reproductive knowledge and abridge their right to make their own decision about childbirth. In his acclaimed work about rural development, Chambers (1983) explains how the knowledge of rural people is devalued in favor of putatively scientific knowledge. Chambers argues that:

> “[T]there is a common assumption that the modern scientific knowledge [claims] of the [West] is sophisticated, advanced and valid and conversely whatever rural people may know will be unsystematic, imprecise, superficial, and often plain wrong. Development then entails disseminating this modern scientific and sophisticated knowledge to inform and uplift the rural masses. Knowledge flows in one direction only downwards from those who are educated and enlightened to those who are ignorant and in darkness” (p.76).

The main problem with the promotion of western scientific/medical discourse in Ethiopian maternal health services today is not that modern scientific health interventions are promoted but that indigenous community-based health practices are being erased in the process. Despite the clear and favorable statement in the policy to integrate traditional medicine and practioners with western medical interventions, in reality the effort is non-

existent (Bishaw,1991; Kassaye et al., 2006). As mentioned earlier, health practioners, with the exception of some of the HEWs I have come in contact with, often demean and disregard the role of TBAs. They also had a strong view that practices TBAs carry out during delivery are not medical and modern and therefore dangerous.[30] Health professionals believe that TBAs should be stopped and discouraged from providing such services by any means necessary. A Woreda maternal health specialist in Amhara expressed his view as follows:

> In order to achieve our objective of zero home delivery and to increase skilled facility-based delivery, we brought TBAs in this Woreda to a meeting together with the police force. We did this so that they understand the consequences that would result from their actions. Last month we put a traditional birth attendant who is also a close relative to the pregnant woman in custody because the woman passed away after childbirth. (Key Informant Interview, Mecha Woreda, Amhara)

To meet government-set maternal health targets some regional and Woreda health institutions and health officials are taking drastic measures such as the one outlined above. These measures are disadvantageous and dangerous for pregnant women and for the TBAs. In Mecha Woreda, TBAs are afraid of being imprisoned and penalized for the services they provide and have started to refuse helping women in communities where there is still a great shortage of health professionals and health resources including ambulances and medical equipment. Women and their communities have no option but to keep such practices a secret in fear of being penalized. This was evident in the focus group discussions in both regions. TBAs would first inform me that they have stopped helping women in times of delivery in fear of being reprimanded and once they realized

[30] Please see chapter four for some of the detailed practices of child delivery TBAs carry out at home.

that I did not come from the ministry/the government office and when they were comfortable to discuss their views, they mentioned that they secretly helped women. In addition, community members affirmed that they still approve of and require the services of TBAs. One of the men in the focus group discussions in Amhara expressed his views as follows:

> This [TBAs being imprisoned and penalized] is very sad. What are we supposed to do when the ambulances are not here and our women are suffering? To tell you the truth no matter what the health officials say we will still help each other. We are neighbors and she [pointing to the TBA sitting across] will not let my wife die just because [health professionals/officials] said so. We help each other and then we get our stories straight.

Government policies and health professionals seem to assume that whatever is traditional is dangerous or harmful. These are the mechanisms in which traditional community health systems are disparaged and modern scientific claims of knowledge are gradually disseminated and maintained as superior in many African nations. Current reproductive health initiatives in many African countries have virtually replaced TBAs in rural villages with health extension workers and scientific midwives (Chintu & Susu, 1994; Choguya, 2013; Morsy, 1995; Roro et al., 2014; Shiferaw et. al, 2012). However, studies including this one have demonstrated that TBAs are valued and trusted among women and men in their community and that the medically trained health extension workers and midwives have little or no experience of child delivery compared to traditional midwives (Roro et al., 2014; Shiferaw et. al, 2013; Temesgen et al., 2012).

Currently, there is a lack of national statistics pointing out the success rates of TBAs and the detailed analysis of the work they do during childbirth. This is probably due to the fact that the government has a "zero-home delivery" strategy that does not

document home deliveries as a success. Nevertheless, the fact that the majority of Ethiopian women still deliver at home points to the reliance of the Ethiopian society at large and over 40 million women on the services of TBAs and their success rates (CSA, 2012). Conversely, since the majority of the women rely on TBAs, the national maternal mortality rates also point to the shortcomings of their services and the unavailability of medical emergency and basic obstetric services to assist women and TBAs in times of emergencies and complications. Hence strategies designed should work to improve both already existing community-based maternal health services provided by TBAs and the overall health infrastructure to improve emergency and basic obstetric care in health facilities. As noted by Pizurki & Mangay-Maglacas (1981), "in many countries many decades will pass before national resources will be sufficient to allow for the development of an adequate number of qualified staff to provide essential health services for the whole society" (Pizurki & Mangay-Maglacas, 1981, p.7-8). In addition, women have mentioned that they prefer to deliver at home for various reasons mentioned above. Hence, it is significant to value, utilize and improve the role of TBAs in the communities while simultaneously working to improve medical health service expansion.

Having an open dialogue about what is useful and harmful about traditional birth attendance will help preserve safe and important community health practices and also address harmful ones. There is a need for a detailed investigation of what TBAs do during delivery in order to design appropriate health strategies to provide the support that pregnant women need. My interviews and focus groups discussions about childbirth in the next chapter partly cover the social interactions and practices of TBAs during childbirth. Therefore, in stressing the significance of TBAs, I am not arguing for a

romanticized idea of exclusively maintaining traditional medicine and the abandonment of medical obstetrical services that Amhara and Oromia women desperately need today. In a context where more than 13,000 women die each year due to lack of access to emergency medical health services, I do not intend to make a privileged assumption of solely depending on TBAs or health facility-based delivery. Rather I am stressing the need to value and integrate local indigenous knowledges of TBAs in addressing maternal health issues and simultaneously improving access to medical health services. In short, I am arguing that valuable knowledge systems and community support might be lost in the process of prioritizing hospital based delivery.

The government approach to stop TBAs was different in Oromia compared to Amhara region. Some health care professionals, particularly nurses and HEWs, recognize the role of TBAs in the provision of maternal health services. They argue for a more integrative approach. A nurse in Oromia explained this point as follows:

> Women in the community will not do anything without consulting people that they trust. They trust and respect community elders and knowledgeable women such as TBAs more than us. Therefore, we have to organize these community members and train them on how best they can help women. (Seden Sodo Woreda, Health Center, Oromia)

Even though this nurse assumes that her health knowledge is superior to that of the TBAs who should be educated and trained, she understands the respect the community has for their knowledge and experience. In addition, the health extension worker from Oromia also mentioned the experience and knowledge she has obtained from assisting TBAs in home delivery. The HEW also mentioned various health and safety issues that she was able to address as they were delivering so that they can both protect the mother, themselves and the child. Providing adequate training for health

extension workers and traditional birth attendants and perhaps designing a program where HEWs and TBAs can work together is a possible way forward.

Modernization and development narratives that seek to shape health behavior and identity are quite pervasive in family planning and community-based strategies. HEW and HDA interventions are meant to go deeper into the community reaching every household. The choice of words in naming women's groups as "development armies" demonstrates the government's intentions to disseminate development and political discourses to every household through these networks. The health education and information HDAs and the community receive from HEWs and other health professionals and the use of "model families"[31] to promote ideas also speak to the state's intentions to disseminate ideas of what is and is not developmental and modern in health and in the process of creating modern "model healthy families" (FMOH, 2015, p. ix). Hence, this is part of the developmental state's health and modernization agenda being promoted at the community level. This is similar to what Chen (2011) notes about the Chinese state's reproductive health policy. Chen (2011) discusses the state's construction of "model modern families" that the Chinese population is supposed to emulate in the creation of a "civilized culture of fertility." The message was that modern families have fewer children in the process of modernization and economic progress (Chen, 2011, p. 42). Chen (2011) asserts that such modernization narratives require the creation of rural communities (particularly women) as backward subjects in need of guidance and regulation.

[31] "Households have been graduated as model families, a strategy through which households are selected and provided with basic training on the 16 HEP (health extension program) packages then monitored regularly to be as models" (FMOH, 2015, p. ix).

Similar to the Chinese reproductive health policy, the health information and dialogue of the HDAs and the HEWs often emphasize modernization narratives with modern biomedical solutions and "model families" of health and development in rural areas. The discourse often revolves around ideas about what is modern/developmental and what is backward and harmful. Indigenous and traditional community health practices such as the ones conducted by TBAs are not integrated into the health dialogue of HDAs. If they are included they are often regarded as harmful and backward. For instance, women who have organized their homes and environment as recommended by the health extension package taught by HEWs and HDAs and those who seek modern family planning services are considered "modern". In contrast, women who follow traditional and indigenous ways of managing the home and environment may be termed as "backward". The idea of backward rural subjects is also quite pervasive among women and men in the Amhara and Oromo community I have visited, particularly in the construction of their identity and knowledge that I will discuss further in the following chapter.

Overall, assumptions about the reproductive knowledge of the community, modernization and health development narratives that are top-down, and drastic policy implementations and legal enforcement to stop TBAs create a policy gap in maternal health services provision. In a nation with limited health resources women cannot afford to lose the support they obtain both from the government and from the communities they reside in. If the majority of Ethiopian women for whatever reason are still delivering at home, the government then would need to reconsider its policy in order to meet the demands of the women it seeks to support. When a government health official was asked

about this particular situation and whether the government would reconsider its health facility delivery based strategy and include other community members such as TBAs as driving forces for the health extension program, the government key informant stated the following;

> There are other countries who have used that route, where they have engaged traditional birth attendants. The route we chose in the past two decades is the selection of young female community health workers. We are among the pioneers in the world for this achievement and we cannot go back or channel our resources in other directions. We have expended a lot of resources to make these community programs work. The policy does not suggest the harsh treatment of TBAs but they should indeed stop their practice and assist the HEWs as community members. (Health official, FMOH)

I contend that this is a missed opportunity for policy implementers to integrate traditional medicine and the socio-cultural comfort women feel in their homes with modern maternal health services that the government provides. Engaging highly respected and valued community members such as TBAs and their knowledge in the process of health service delivery is a key intervention that is missing in the health policy implementation. Government policy makers have clearly noted the socio-cultural, economic and reproductive challenges of maternal health. This is evident in the health policy statements outlined to address these reproductive and maternal health challenges in a comprehensive manner. However, the gap remains in the solutions and implementation. The implementation strategies promote development and modernization narratives that only focus on biomedical solutions without due consideration to the pre-existing community-based health interventions. It appears that the selection of community members for the community innovative strategies has come from the top. Hence, refusing to engage community members in the creations of policy interventions

have resulted in well-intentioned strategies that do not actually address the community's needs.

Conclusion

Maternal health is one of the programmatic areas that has suffered a financial blow over the past decades in the Ethiopian health system as a result of global market-oriented economic development programs. Despite minimal change in finances and actual implementation of maternal health services, the nation has strived to employ favorable and alternative international health and development frameworks such as the primary health care approach, MDGs and SWAPs to improve maternal health service provision and fund management. The most recent example of such effort to improve maternal health has been the recent provision of free delivery services for pregnant women despite limited health financial resources. However, such implementation changes come at a cost. These programs are marked with inadequate funding and lack of support from external sources. With the current rate of funding, the changes in maternal health outcomes will be gradual and lacking quality.

Although the health ministry has made an effort on the one hand to push back against global economic development agendas and has strived to create a comprehensive policy document, the nation's innovative community-based health implementation strategies are marked with underlying development and modernization narratives and assumptions that undermine the knowledge and reproductive desires and needs of women. Community-based maternal health initiatives such as HEWs and HDAs, despite their comprehensive and gender sensitive outlook, have a modernization and development aspect that constructs local women and their communities as "passive",

"ignorant" recipients of maternal health knowledge and services. In addition, socio-cultural factors such as age, political biases and lack of experience of HEWs, deter the effort underway. Moreover, health care professionals and health officials consider local indigenous maternal health practices carried out by TBAs as backward and dangerous. This is despite the fact that rural women and their communities value their knowledges and continue to utilize their services. This is the knowledge gap between the government and community.

In a context where women prefer to deliver at home, there should be a way to bring clean and safe delivery to their homes. Deliveries that are currently not taking place in health posts and health centers are taking place at home. Until the capacity of the health system to adequately finance maternal health services is enhanced and rural women can easily and willingly access health care services, there will be a huge gap between service and demand. Instead of an entirely "zero-home delivery" strategy that seems out of touch with the reality of many rural women, the government could devise mechanisms where HEWs and TBAs could assist women at home. In addition, there needs to be a policy shift in how traditional practices are perceived by health care professionals and the implementing entities must find ways to integrate these practices into their strategies to address maternal health.

Family planning and fertility-related strategies and policies also focus mainly on preventive contraceptive provision without due regard for the reproductive desires and needs of women and their community. This acceptance of western medicalization and population control ideologies that have been falsely linked to development and progress deter the actual progress and development of the nation. Numerous studies suggest that

better living standards and improved economic conditions of the masses lead to better health outcomes and population stabilization (Hartmann, 1995). Hence, government must address population stabilization or control in relation to the underlying social and economic problems the population at large and women in particular face. Policies and strategies that assume that women are unaware of family planning and maternal health services, in general, need to be changed in order to design appropriate interventions addressing women's actual reproductive and maternal health desires and needs.

CHAPTER FOUR

SOCIAL DETERMINANTS OF MATERNAL HEALTH

Chapter two and three mainly have addressed global and local development and maternal health policies and their impacts on actual maternal health service provision. As we have seen in chapter three, there is a disconnect between Ethiopia's innovative, gender-sensitive health strategies such as the deployment of HEWs and HDAs and women's actual engagement in and use of these community-based health strategies. As I have noted earlier, the Health Policy primarily focuses on biomedical solutions such as training health professionals, building health facilities and infrastructure and providing family planning services. The lack of emphasis on the social factors of maternal health that women and their communities experience further exacerbates the gap between policy and implementation. Policy statements and implementation strategies rarely address underlying social causes identified in various studies (including this one) (FMOH, 2006). At most, socio-cultural factors are targeted through health information and education programs that sketchily discuss the social issues or that mostly focus on legal enforcements (FMOH, 2006, 2013, 2015; National Committee on the Traditional Practices of Ethiopia [NCTPE], 2008).

A comprehensive understanding of maternal health issues requires examining intricate social systems at multiple levels.[32]Dudgeon and Inhorn (2004) explain that "while the notion of reproductive rights is usually conceived of in terms of individual persons, reproduction never involves single individuals and rarely involves only two

[32] WHO. Social Determinants Approach to Maternal Health: Dead Women Talking Initiative. Retrieved from. http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/india-social-determinants/en/

people. Instead, reproduction often lies at the intersection of group interests, including families, households, kinship, ethnic, and religious groups, states, and international organizations" (p.1380). Global health policies outlined by the WHO recently have attempted to engage social inequalities and the social causes of maternal health complications. According to various studies conducted in Africa in general and in Ethiopia in particular, social causes of maternal health complications at the community level include: poverty, lack of education and information, socio-cultural factors such as early marriage and other harmful traditional practices, power relations between men and women, women's lack of autonomy and decision making and overall empowerment (Dudgeon & Inhorn, 2004; Gurmu & Dejene, 2012; Kaba et al., 2016; Pacagnella et.al, 2012; UNFPA, 2008).

In this chapter I discuss the socio-cultural and economic factors that shape women's maternal health experiences in Andenet and Mudena Ibayyuu Kebeles from the perspectives of women and their communities. Accordingly, I have attempted to understand women's views and experiences related to education, income, gender constructions, age, marriage, religion, family planning use, fertility, infertility and the traditional process of childbirth. I specifically investigate women's reproductive desires and needs in light of their social contexts. This chapter primarily analyzes and discusses findings from the interviews and focus group discussions conducted with women and their community. I began my inquiry with the view that women and their communities have a better understanding of these social conditions. Hence, I have made an effort to understand the complex ways women and their communities experience and engage in these social interactions.

Education: Development Narratives and Identity Construction

Global and local health policies and various studies on maternal and reproductive health discuss education as a solution for maternal health complications (Dudgeon & Inhorn, 2004; FMOH, 2006, 2013, 2015; Gurmu & Dejene, 2012; Pacagnella et.al, 2012; UNFPA, 2008). Numerous studies discuss the lack of education and information as one of the major causes of maternal health complications while going to school, especially the promotion of girls' education, is discussed as one of the ultimate solutions to prevent reproductive health problems. Many biomedical and social studies also suggest that education and "investment in schooling is an important means of improving economic growth and wellbeing" (Gebremedhin & Mohanty, 2016, p.1). However, few studies have discussed how local and global development and modernization narratives in education shape communities' value of knowledge and their identity constructions. Also, few have questioned whether formal education in its current form has brought about significant change in maternal health and the lives of women. Consequently, I explored what education means to women and their communities, whether they have attended formal schooling, the challenges/barriers and opportunities to education particularly for girls and boys and what they generally regard and value as knowledge in their communities. I also sought to understand how education in its current form shapes or influences Amhara and Oromo women's maternal health outcomes.

We are "Dumb", We are "Ignorant"

One striking but contradictory discussion I had with the communities I visited was about knowledge and their views on education. When I asked research participants what they considered knowledge and the type of education they have acquired so far,

many explained that they are “ignorant” and “backward” and that they have not gone to formal schools. This statement defines the community’s internalized views about who is considered backward and who is considered modern based on the level of formal education one has attended. Of the ten women I interviewed in Mudena Ibayuu, the majority (seven) did not attend formal schooling while the remaining (three) went to school and dropped out from 1st, 7th and 9th grade respectively. Similarly, in Amhara, Andenet Kebele, seven of the ten did not go to school, while the other three attended school and dropped out at 1st, 5th and 6th grade respectively. Out of the five men I spoke with in Amhara, two attended school and dropped out during elementary school and the other three did not receive formal education. In Mudena Ibayyuu four out of the five men did not attend formal education and one has attended up to 6th grade. Thus the majority of participants have not attended formal education and those that have attended have dropped out from elementary grades.

The value Ethiopians give to formal forms of education in itself, both local and global, is evident in the discussions I have had with participants and in the historical development of the nation. In her discussion about African indigenous communities and knowledge, Njoki Wane (2005) notes the effects of colonization and western, modern education on the indigenous knowledge and communities of Africa. She argues that westerners (colonizers) have succeeded in destroying and devaluing the ways of teaching and knowing of indigenous communities of the world (Wane, 2005, p.32). Similarly, I found that neo-colonial and imperial influences through education have shaped the way many Ethiopians view their pre-existing knowledge systems.. Locally, Ethiopian traditional education was highly valued and was often accompanied by prestige, class,

economic and political benefit (Wagaw,1990). For instance, the traditional educational system of the Ethiopian Orthodox Church[33] had very high value in Ethiopia, particularly in Northern Ethiopia. Church education was the dominant and formal form of education in Ethiopia during the imperial regimes. It started in the kingdoms established by the Christian Highlanders in the North and it later expanded to other parts of the nation. The church and the state were intertwined. Hence, having a church education meant that the individual would have power and privilege in the form of wealth and high social status (Wagaw, 1990). As Ethiopia moved towards modernization and development in the 19th and 20th century and as the church and the state gradually separated, traditional church education was relegated and confined to the church (Ibid). The church education that had high value in these communities lost most of its economic privilege and today is limited to the realms of the church. Priests, however, particularly in Amhara, still have high social status and influence in the communities they reside in.

Modern education has replaced church education in providing social, political and economic benefits that are valued in the Ethiopian society. Therefore, when individuals attend formal education, communities assume that these individuals have better knowledge and better income compared to those who did not attend formal education. Identities and values of knowledge in Amhara and Oromia are thus constructed in

[33] Note: Christianity in Ethiopia began in 340 AD through Ethiopia's trade and socio-historical connection with the Middle East. King Ezana of the 4th Century is known to have established and expanded Christianity throughout the kingdom. Ethiopians' understanding of their lineage to king Solomon of Israel through Queen Sheba is a history that had great significance in establishing and maintaining a Christian Kingdom for over 2000 years (Deressa, 1967; Mekuria, 1969). Unlike other African nations, Christianity did not come as a result of western colonization. The nation has its own Christian tradition with its own religious rituals, its own language and interpretations of the biblical texts, saints, art and portraits. Most importantly, the Ethiopian Orthodox Christian Church has established and maintained written documents and manuscripts about the nation's history as far back as the 10th century B.C (Issac, 2013). This makes Ethiopia among the few nations in Africa with the oldest manuscripts of written history.

relation to one's attendance of formal education and social and economic prestige that result from it. The fact that most participants have not attended formal education points to their lack of social, political and economic prestige that accompanies it in their society. Most participants discussed modern, formal education in terms of "coming out of the darkness". They also mentioned that going to a health facility and delivering there is the "modern" and "civilized" thing to do as modern health practices are also the byproducts of modern education. Women and men in the interviews also explained that their way of life in general, health remedies and giving birth are backward. An FGD participant in Oromia explained that, "Education [modern education] is useful because it is the means of coming to light out of the darkness of ignorance. Being educated brings change in life. Through education one begins to see the light" (FDG, Oromia, Mudena Ibayyuu).

Participants' views about formal education and how they have constructed their identities in relation to formal education shows the hierarchy that values modern western education and devalues their own traditional knowledge. African indigenous scholars have documented indigenous peoples' internalization of modernization and development narratives that view indigenous communities and their knowledge as backward, barbaric and that often describe them as being in the dark and without knowledge (Chilisa, 2012; Uchendu, 2008; Wane, 2005). These narratives prevail in current rural communities in Ethiopia. Many of the research participants both men and women in Amhara and Oromia describe themselves as living in darkness and ignorance and how modern education and healthcare services are better than what they know and value in their community.

Recognizing the power dynamics that exist between western forms of knowledge and indigenous knowledge systems, I further explored what education and knowledge

signifies beyond the scope of formal education in order to understand and include other forms of knowledge in this research and specifically to explore the ways in which traditional birthing practices are viewed and maintained in the communities. Indigenous worldview describes education as the process of learning and sharing of knowledge, ideas, values, beliefs and norms through various mediums including storytelling, generational transfer of knowledge, school training, etc. (Chilisa, 2012; Kovach, 2011; Wane, 2005). My probing allowed participants to recount their ways of knowing in their day-to-day lives. In the FGD conducted in Oromia, a participant explained ways of acquiring knowledge specifically about traditional childbirth practices as follows:

> We can acquire knowledge in two ways: from practice and by going to school. Knowledge is not only becoming literate. It includes the practical experience handed down to us from our parents and the society. For instance, we learn about farming from our fathers. Likewise, in a family of seven members, when a mother helps a woman deliver a baby through traditional knowledge, all seven family members learn by observing. (FGD, Oromia, Mudena Ibayyuu)

A traditional birth attendant in Amhara also mentioned how she became a TBA in order to preserve the knowledge transferred from her mother and grandmother. Traditional healing practices are also another major form of knowledge that participants discussed. Women explained some traditional healing practices and medicines they use in times of illness. They noted that the pain management and healing herbs are also used during pregnancy or delivery depending on the benefit or harm it may have for the baby and the mother. Some traditional healing practices from Amhara and Oromia were as follows:

> We have been taught to use things like ginger, garlic for the treatment of stomach cramp, or we use the juice of certain plant leaves called *Damakasse or Mich*

> *Medhanit* for the relief of fever and other sudden diseases. If the ailments are serious we decide to go to the clinics. (Interview, Amhara, Andenet)

> We use herbal concoctions/mixtures like *Koricho Michu* or *Fetto* used as potions applied on the body or burned for inhalation when children are sick. We do this at home before taking them to the clinic. These medicines are effective and sometimes they help; but not always. In which case, they must be taken to the clinics. (Interview, Oromia, Mudena Ibayyuu)

The above quotes describe women's health knowledge and their primary preference of treatment. All participants from both regions stated that they first use traditional health remedies before going to the health centers or clinics. Other scholars who have conducted similar studies on herbal and traditional medicine use during pregnancy noted that women in other parts of Ethiopia also use garlic, ginger, tenaadam, damakasse and eucalyptus as health remedies (Laelago et al., 2016; Mekurai et al., 2017). This shows the communities' reliance on and deep-rooted attachment to their traditional health knowledge. Despite their insistence on the benefits of modern education and the use of modern health practices, in reality research participants use their own traditional knowledge systems in their day-to-day lives and to address illnesses and maternal health complications. Research participants also mentioned various life skills and concepts of identity that they have acquired from their society. A woman in Oromia explained her experience as follows:

> I have not pursued formal education but I have learned farming, how to do household chores like baking *Injera*, cooking food, washing clothes taking care of children and cleaning the house and the stables etc from my parents. I have also learned embroidery and other things that women do when they are married from my mother and the women in my family. (Interview, Oromia, Mudena Ibayyuu)

The dilemma in looking at education as a remedy is that even though participants assert that their knowledge as a community is backward and that modern education and

medicine are preferred, women and men in both regions rarely choose to use medical services in actuality. Their reliance on these traditional community-based knowledge systems denotes the existence of a modernization and development narrative that is highly internalized and that seems to clash with their community-based support and indigenous knowledge that is still relevant and that they are deeply attached to.

Therefore, based on my interviews and observation, I argue that formal education with its development narratives exists in a paradoxical relationship with indigenous, traditional knowledge systems where indigenous knowledge is discursively relegated and disparaged, but in practice widely employed. Women and men have a deep attachment to their indigenous ways of life that they nonetheless described as dark and ignorant. National health policies and programs, therefore, must understand and address these dilemmas to integrate traditional and modern health remedies and maternal health practices. My discussion of development narratives in the policies and the views of health professionals towards women and their community in chapter three also relates to how these health professional as "educated" subjects with the social, political and economic privilege have constructed women and their communities as ignorant rural subjects through their interactions and health education. Communities in turn confirm their exclusion from health policies and programs by expressing their views and knowledge as backward. This is also connected to the health education provided through HEWs and HDAs of the government that I discussed in chapter three. Hence examining these dynamics might assist in future policy and program formulation.

Socio-Cultural and Economic Challenges to Girls' Education

Another crucial dimension to formal education that is worth examining is its potential benefit of delaying early marriage and early pregnancy and preventing maternal health complications for women and girls. Studies affirm that education is an important strategy that may result in reduced fertility, improved child health and women's productive engagement in the formal economy (Lincove, 2009). These studies and the National Reproductive Health Strategy affirm that fertility rates are high in rural areas where the majority of the population reside and do not attend formal education (Alemayehu et al., 2010; Ayele, 2015; CSA, 2012; FMOH, 2006). Other studies in Ethiopia have also shown the low value placed on women and girls' education in the society. Low literacy and enrollment and high drop-out rates for girls in Ethiopia correspond with the age of marriage in the community (CSA, 2001; FMOH, 2006).

However, numerous studies have challenged the neoliberal development framework in which education in many third world nations has been set up (Chant, 2016; Liconve, 2009; Murphy, 2016; Switzer, 2013). Education in these settings only functions to prepare women and girls for the cash economy and as a means of limiting their fertility. Murphy (2016) notes how world financial institutions' leaders calculated and proved that the education of girls is much cheaper and more effective in limiting fertility than contraception. Hence investing in girls' education was targeted as the new development agenda (Murphy, 2016). Also, as stated in chapter three, Ethiopia's reproductive health strategies and programs discuss sending women and girls to school as one of the priority solutions to limit fertility and address reproductive and maternal health issues. Lincove (2009), however, argues that the education markets will not improve

gender equity and women's health outcomes unless other socio-cultural and economic factors are considered. The study likewise highlights the need to consider other social and economic factors before claiming that education is a maternal health solution.

As mentioned earlier the research participants of both regions recognize the social, political and economic benefits of formal education. However, for various socio-cultural and economic reasons education is not accessible and convenient for them and their children. Participants from both regions discussed the significance of education and their aspiration to send their children to school. However, as I learned from both the interviews and FGDs, many families still do not send their children to school or send them in shifts. One participant explained the challenges of sending children to school as follows:

> People have to work here and there is a lot to do and because of that we keep children home for work. Both boys and girls tend cattle, weed the field, get grass for the cattle and fetch water. When children go to school parents say our children are not obeying our rules or they are not helping out. After children come from school they want to study but we want them to work so it is a struggle (Interview, Amhara Andenet, woman).

The decision not to send children to school thus is not always tied to parents' or families' lack of knowledge or "ignorance" as argued by many international and national development and reproductive health programs. Many participants explained that their decisions are mainly due to the subsistence way of life and the requirements of productive labor in those settings. As explained in chapter three, national reproductive health strategies do not take into account the economic factors of subsistence life where children are needed as a source of labor. The irony is that the nation almost entirely depends on subsistence agriculture and the labor of individual rural farmers for food

security and the country's economic gain, while simultaneously condemning these farmers for not sending their productive source of labor and support (children) to school.

Women and girls in particular face cultural challenges and barriers within their communities when they decide to go to school. Early marriage, abduction, distance to schools and parents' decision on the basis of gender and age present a challenge for girls who want to pursue their education in these areas. A young woman explains how she wanted to attend school but had dropped out of school because of marriage and her parents' disapproval.

> I used to go to school. I was in the 1st grade when my parents pulled me out of school to help them look after cattle and to have me married. They did not have a young boy who could become a shepherd so they made me one. It was in between marriage that I started going to school. However, I dropped out because my dad disapproved and he wanted me to marry again. (Interview, Amhara, Andenet Kebele)

There are various dimensions to the challenges girls face when pursuing their education. House work and early marriage deterred the above participant from attending school. Other challenges to girls' education in both regions include distance to school, fear of abduction and gendered preferences. Participants in Amhara for instance explained that students must walk one to two hours on average to get to the nearest elementary school and about six hours to the nearest high school (usually high school students rent small rooms in town and these are additional costs parents incur). Participants from both regions also explained that girls are afraid of travelling alone and that they often must wait for the male students to accompany them to school.

> Girls are afraid to travel to school alone. In this area girls wait for the boys in their neighborhood and they go together. If the boys do not go, the girls do not go as well. They are afraid to go to school alone because they are afraid of being raped or abducted. (Interview, Oromia, Mudena Ibayyu)

Government and the community must address the dependence on male students to go to school, the lack of autonomy and fear of abduction and early marriage for girls to successfully attend school. In addition to the daily chores of field and house work, age and gender have a lot to do with the decision to send children to school. The preference to educate boys and not girls is evident in the discussions with men and women in both regions. Participants in both regions also mentioned that for boys it is more likely that they will be pulled out or they will drop out of school when they are younger because they are expected to help in the fields. Girls often drop out when it is time for their marriage. Interview participants explained that girls might dishonor parents if they are abducted or if someone marries them without the family's consent. A participant in Andenet Kebele explains as follows:

> Children go to school in our area now but of course parents choose who to send when there is a lot of work to do at home. They mostly send boys than girls. Also, little ones will stay at home and older children will go. For example, my father had to decide to keep one of my siblings (the youngest) at home since there was no one to tend to the cattle. (Interview, Amhara, Andenet)

Another major socio-cultural issue related to education is that young women in rural Ethiopia who have gone to school and who are not fortunate enough to have made it to the top 1-2 percent of the population that go to higher educational institutions, often remain unemployed and are exposed to rural-urban migration and deeper levels of urban poverty (Gebre, 2012). If they do not migrate to urban areas, these young women must re-immerse themselves into the culture and community from which they have been separated. As Wane (2005) notes "foreign language and concepts as mediums of education served/serves to make students foreign within their own culture, environment

and creates a colonial alienation." (Wane, 2005, p.34). The girls will likely experience alienation in the culture and community they grew up in as result of the modern education they have acquired. At the age when girls complete their high school education, they are considered late for marriage in their communities which is a significant aspect of women's lives in both regions. A father explained the dilemma he has about sending his daughter to school. He also points to the alienation girls feel from their community as a result of education.

> If she has to go to secondary school in Chulule, there will be a problem. Therefore, I have to think of getting her married. Because a girl who has reached grade 10, are not interested to live in the farm and clean the shed. The husbands around here also are not interested to marry an educated girl. (Interview, Mudena Ibayyuu, Oromia)

The socio-economic conditions discussed above and maternal health problems of women will not be resolved by simply sending girls to school. The government needs to conduct further in-depth studies and dialogue with the communities in order to understand and design programs that address both economic and cultural factors that impact education. It is necessary to consider issues such as livelihood and the subsistence form of life as well as the gender constructions and cultural practices that affect girls' education such as abduction and early marriage in the community. Education must be designed to fit the daily lives and needs of the majority of the nation's population who live and work in rural areas. Even though education can be a great solution to delay marriage and to limit pregnancy when a woman wishes to do so, education, due to poverty and socio-cultural practices that particularly target women and girls, often is not an option for many women in rural Ethiopia.

Economic Conditions

Numerous studies have examined the direct correlation between households' economic status and maternal health outcomes (Ansong, 2015; Benova et al., 2014; Tarekegn et al., 2014). Low economic status affects families' decision to access maternal health services and it also affects nutritional health of women and their families (Woldemariam & Genebo, 2002). Scholars have pointed out the need to look at gender and economic status of the household when addressing maternal health issues (Berhane et al., 2001; Gurmu & Dejene, 2012). Consequently, in this section I discuss the gender division of labor, ownership, access and control of assets, income, and the ability of women to make decisions on these assets. Investigating each variable provides a better view of the economic status of the households and women's decision-making and autonomy in accessing and utilizing these assets for their wellbeing.

Agriculture is Ethiopia's leading sector that produces the highest percentage of foreign exchange earnings and accounts for 85% of total employment, the supply of food for domestic consumption, and the manufacturing of export commodities (GOE, 2012)[34]. The research participants in both regions are primarily engaged in agricultural activities such as farming, animal husbandry and the trade of farm goods. Most of the food items they produce are cash crops for sale and many of the participants have noted that they do not produce enough food for domestic consumption.

As noted in chapter two the globalized economy has a huge impact on the livelihood of rural farmers. Poverty is an indirect impact of market-oriented global

[34] Ethiopian Government Portal (GOE). (2012). Retrieved from http://www.ethiopia.gov.et/web/Pages/Economy

economic development that affects women's health and wellbeing (Grown et al., 2006). Despite being the major agricultural producers in the world (60-80%), women - particularly third world women- earn a tiny portion of the profits from agricultural products and their contribution is often invisible (FAO, 2013; Hartmann, 1995). In addition to being the largest livestock exporter in Africa, Ethiopia also exports coffee, sesame seeds and chat among other cash crops.[35] Ethiopian women are involved in major agricultural activities, working on average about 14-16 hours a day on various agricultural activities, yet they often earn the smallest portion of the profit if they earn any at all.[36] Hence, global economic conditions have resulted in the abject poverty rural Ethiopian women and their families live in.

Participants from Andenet and Mudena Ibayyuu Kebele have noted that they produce between 15-50 quintals in Andenet and 10-50 quintals in Mudena Ibayyuu per year and they sell whatever they have produced at very low prices (1quintal =100 kilograms). The annual income levels mentioned range from 10,000-50,000 birrs per year in Mudena Ibayyuu and from 10,000-35,000 birrs in Andenet (1USD= 22.9 birr). Hence the highest earning families will make about 4-6 dollars per day in these regions while low-income families make 1 dollar a day. It is important to note here that most of the participants were in the lower income range and that out of the 30 interview participants only 3 mentioned the relatively higher income ranges of 4-6 dollars. Some have also mentioned that it has been years since they stopped consuming the staple food/grain Teff. The participants in Andenet Kebele noted that they have not been able to consume Teff

[35]Fact Sheet: Livestock Ethiopia.(2010). Livestock in Ethiopia and opportunity analyses for Dutch investment.

[36]Retrieved from http://ilri.org/infoserv/Webpub/fulldocs/Workp27/Gender.htm#P238_53422

for the past five to ten years because of the high prices of fertilizers, taxes and other production costs. Therefore, they mostly produce *Teff* for national consumption and export. While we have seen the impact of global economic development on maternal health services at the national policy level we also see how it shapes women's lives at the local and community level.

Overworked and Malnourished

Women make up the main productive work force in rural Ethiopia. The condition and number of hours worked and economic situation of the household has a lot to do with the health and wellbeing of the individuals in the household (Woldemariam & Genebo, 2002). These working conditions also provide an idea of what women must deal with during pregnancy. To have an idea of the gendered division of labor and the number of hours worked I asked the participants to describe what their day looks like on a regular basis. Most of the women and men in both regions stated that they work between 13-16 hours a day. Most expressed the taxing nature of field work and traditional farming[37], walking long distances to fetch water and firewood, household chores and looking after children. However, participants from the interviews and focus groups agreed that women work longer hours compared to men. Women multi-task between household chores and farming which creates an additional burden for them. Many women and men described that they work most of the day, six to seven days a week and rest on religious holidays and Sundays from farm work when they go to church. It is important to note here that

[37] Ethiopian farmers use age-old farming methods. The hardship is partly due the traditional ways of farming using oxen drawn ploughs without new technological advancements. This requires the family's collective effort which in turn forces families to require the labor of their children and the wives etc.

women are not free from daily household chores during the resting days. A participant explains her daily activities as follows:

> I wake up at six in the morning and clean the house and the stable. Then I fetch water, wash clothes and then come back to take care of the children. I work in the farm helping my husband with weeding and other farm activities. Then I come back early to prepare lunch and coffee once lunch is done I start to prepare supper or depending on the season I go back to help my husband on the field. At the end of the day's work I go to bed at ten and sometimes at eleven at night. The children and my husband usually go to bed at eight or nine. I am very exhausted when I finally finish my day's work. (Interview, Oromia, Mudena Ibayyuu)

Women in Andenet Kebele also described similar working conditions. The description reveals the amount of time spent on their livelihood and the burden women have of taking care of both house and field work. This gender division of labor significantly over-burdens women with the task of fetching water and firewood from long distances and from assisting in the field. Households that have children who assist them in fetching water and fuelwood or in the farm significantly reduce the burden on the men and women. A young girl reduces the burden of the mother and a young boy assists the man with the farm activities. Significantly the circumstances are also not easy for men in rural areas. However, men in both regions have mentioned how women sleep less at night and work more in the house. Once men complete their work in the field at about 5 or 6 pm, they have the opportunity to rest for a while and then feed the cattle or retire for the night while women continue to work in the house. A man from Mudena Ibayyuu explained his daily activities as follows:

> I get up at six in the morning and take out the oxen and the other animals for grazing. After breakfast, I go to the farm where I will work until five in the afternoon. After getting home, I will rest a little while the children. After dinner, I look after the oxen up to eight thirty or nine at night while they graze. After they enter their sheds, we retire for the night. (Interview, Oromia, Mudena Ibayyuu)

One can imagine pregnant women in these settings. Many women in this study and in other studies have noted how tiring and time consuming it is for them to walk many hours to the nearest health facility for antenatal and postnatal check-ups in addition to the daily activities they must perform at home (Tsegay et al.,2013). Women in the FGDs and interviews, have noted that most women in their areas do not go for antenatal and postnatal check-ups due to the distance of the health facilities from their area and their daily chores. Scholars who have specifically investigated antenatal access in the different regions of Ethiopia have noted the importance of providing these services closer to home or at home for rural Ethiopian women (Regassa, 2011; Tsegay et al.,2013). Hence, interventions in these regions should also consider women's day-to- day activities when promoting the use of antenatal and postnatal services.

Despite their hard work many Ethiopian women including the ones in this study eat and sleep last in the household. A nation-wide survey conducted by the National Committee on Traditional Practices of Ethiopia (NCTPE) found that many Ethiopian women in all the regions of the nation experience a stunted growth because of their arduous daily tasks and cultural values that make them vulnerable to malnutrition (NCTPE, 2008). In Ethiopia, cultural preferences of feeding men and children first and women eating what is left over are prevalent in almost all the regions, with high occurrence in both Amhara and Oromia (NCTPE, 2008).

Woldemariam & Genebo (2002) note that "some evidence in developing countries indicate that malnourished individuals, that is women with a body mass index (BMI) below 18.5, show a progressive increase in mortality rates as well as increased risk of illness." (Woldemariam & Genebo, p.2). In addition, rural women in their reproductive

age are the most vulnerable to malnutrition due to their social and biological conditions. Adequate food supply and nutrition are highly linked to the economic status of the household. Pregnant women from low income households are the most affected by malnutrition (NCTPE, 2008; Woldemariam & Genebo, 2002).

Assets and Income and the Decision to Access Maternal Health Care

Studies have documented the significance of women having access to and control over assets for the health decisions they make (Berhane et al., 2001; Gurmu & Dejene, 2012). I inquired about the various types of assets participants owned or had access to in the communities I visited. Many noted that they owned land, cattle and grain as a household. However, when I asked women about their ability to access or make decisions about these assets such as buying or selling, most explained that they had access to these assets but no say over selling or buying them.

> We have land, cows, oxen, chickens, sheep and a donkey. My husband is the one who can sell these properties. He has control over these assets. Apart from the items I use in the house like pots, pans and other small things. I cannot decide on our most valuable assets. (Interview, Amhara, Andenet)

The ability to make decisions about these assets is crucial when emergencies arise. In an in-depth study about women's health and social status in rural Ethiopia, Berhane et al. (2001), similarly explained that women often lacked the power to decide on property ownership, access to health facilities, mobility and economic means. Even though government has emphasized free cost of delivery and transportation during emergencies, trips to health facilities for check-ups and even for other reproductive health services are costly. Unless women have their own income or the economic means such as assets to use during health complications, improving their maternal health will be quite

challenging. Some women have noted that they decide together with their spouse on the use of these assets or that they have a separate but minimal income that they use for their own purposes. These women and their households could be models in the reproductive health education programs of the government to demonstrate improved gender relations in the household that are favorable for women's maternal health and wellbeing.

> But there are things I decide on, when my husband provides the grain for consumption. I can make Areki (local alcoholic drink) and other things and sell them in the market. Whatever I earn from that is my own money. I usually make about 100-200 birrs (5-10 $) and it will last me a month. (Interview, Amhara, Andenet)

Development Remedies for Poverty

It is important to discuss economic development programs and poverty reduction strategies promoted by the international financial institutions. As I have discussed in chapter two, there are various approaches in development to address poverty and to improve women's livelihood. However, as most feminists have noted these strategies only focus on engaging women in the economy using the WID approach. Feminists have argued that a neoliberal, market oriented development creates rural women and girls as driving forces of the economy, making them cheap and easily replaceable and exploitable urban laborers with fewer skills. This prepares young women for exploitation rather than adding benefits in their lives (Aguinaga et al., 2013; Brown, 2006; Chant, 2016; McRobbie, 2009). Income generating and livelihood programs designed in the WID approach often do not considers women's daily chores and roles in the household and in the farm (Aguinaga et al., 2013). The government of Ethiopia, and international and national non-governmental organizations have set up numerous women-centered programs and income generating activities that have failed to consider women's working

conditions. For instance, a previous study on biogas mass dissemination conducted by the Ministry of Agriculture and a consulting firm revealed that biogas plants meant to ease the burden of rural women by providing electricity and fuel in the house required women to fetch additional 20 liters of water and to prepare an additional two kilograms of cattle dung that they may not be able to acquire.[38] Some small income generating activities (IGAs) with micro-credit loans from the government at times have placed women in debt and deeper poverty that they are unable to cope with.

Hence, programs to alleviate poverty and to ease the economic burden of women and their communities need to consider the actual working conditions of women and their families to find strategies that would either save their time or improve their productivity in the agricultural work that they are already engaged in. Participants in this study have mentioned that they are aware of income generating and micro-credit programs in their areas. Most of them explained that they are not engaged in such economic activities.

Marriage, Fertility and Childbirth: The Construction of Gendered Identity

Another major socio-cultural factor that shapes maternal health outcomes in Ethiopia is marriage. In Ethiopia, childbirth and maternal health issues generally occur within the context of marriage (Gurmu & Dejene, 2012; NCTPE, 2008). A 2008 nation-wide survey conducted by the National Committee for Traditional Practices in Ethiopia reveals that nearly 50% of Ethiopian women nationally and 82% in the Amhara and 36% in Oromia region are married below the age of 15 years (NCTPE, 2008). Recent studies also show that age at marriage has not increased over the past several years (CSA, 2012).

[38] Abcon. (2011). *Baseline study for the mass dissemination of biogas plants in Ethiopia*. SNV, Abcon Consulting House and the Ministry of Agriculture. Unpublished Report.

The revised family code states that the legal age for marriage in Ethiopia is 18 (NCTPE, 2008). However, customary early marriage is more prevalent in the rural areas where most of the population reside. According to the recent demographic and health survey the national average age for marriage is 16 in Ethiopia (CSA, 2012). Studies also note that almost half of the girls married between the ages of 15–19 in Ethiopia have already given birth, with the first births occurring in marriage in 96% of the cases (Gurmu & Dejene, 2012; NCTPE, 2008; FMOH, 2006). The WHO states that young first time mothers (15-19) are at a greater risk of death and complication as compared to older ones (24-29) (WHO, 2014c). In Ethiopia, marriage is often immediately followed by pregnancy. Communities pressure married couples to have children in the first two years of marriage (NCTPE, 2008). Consequently, there is a need to understand what marriage entails for Amhara and Oromia women and the age and gender constructions in the context of marriage that influence maternal health outcomes.

Marriage bestows a sense of pride and honor for women and their families in both the Amhara and Oromo communities. In giving away their daughters' hand in marriage, families enter a blood relationship and kinship with other families. As Gayle Rubin (1975) notes in her analysis of kinship and marriage "the exchange partners [in this case the families] have become affines and their descendants will be related by blood" (p. 36). Both Amhara and Oromo participants explained the significance of marriage in perpetuating family lineage, creating kinship, economic support and societal honor specifically for the woman's family. The importance of kinship and familial ties implies that marriage is not only a husband and wife affair in the Amhara and Oromo contexts but rather a merger of two families where the parents and elderly men and women have a

tremendous role in the decision-making processes of the young couples. Most of the women and men in this study explained that it was their families that had arranged their marriages for them. Families make the decision to create such ties and kinship with other families. They call it "eating together" meaning let us feast and celebrate our union. A young woman in Amhara described her experience of marriage and the role of her family as follows:

> I was married at 15. My parents decided to have me married so young. I did not even know that I was going to get married. However, I did not want to disappoint my family or go against their will. My husband sent a letter to my family and sent money. Usually the husband's family or the husband send money, gold, cloth or cattle to the girl's family. If the husband brings two cows or oxen, then he has brought 10,000 birrs. In addition, the husband's father will give part of his land to his son, to help him establish his own life. (Interview, Amhara, Andenet)

Even though other studies have noted that there is no established bride wealth tradition in the Amhara culture, the discussion with participants in this study seems to point towards an emerging trend of monetary exchange and economic benefit particularly for the family of women involved in the marriages conducted in both Amhara and Oromia regions (Hannig, 2012). Many of the participants mentioned gifts in the form of money, cattle, land and other assets for the wife and the newly wedded couples provided by the husband's family. Similarly, participants in Mudena Ibayyuu described monetary compensations to the woman's family. A man in Oromia explained as follows:

> The process of marriage begins when the boy's parents send elders to the family of the girl to ask for her hand in marriage. Following the consent, there is the ceremony of betrothal at the presence of elders and family members. At this ceremony, the boy's family presents dowry. In previous times, the amount was small, about Birr 36. Nowadays it has gone up. For example, when I arranged for

> the marriage of my children, we had to pay from Birr 14,000 up to Birr 15,000[39]. (FGD, Oromia, Mudena Ibayyuu)

Hannig (2012) notes the significance of land, property ownership and land reforms in relation to marriage among the Amhara. Hannig (2012) suggests that age at marriage may have decreased over time in relation to land reforms. During the imperial regime, families could own and transfer land to their children in the form of inheritance. Current reforms however have prohibited inheritance and land has become the property of the state, where couples are required to register as a household in order to lease a piece of land. Therefore, families marry off their children at a very young age to obtain land through the new households. In most of my discussions with Amhara and Oromia women and men about marriage, the women often emphasized land and property ownership.

Even though land is a very crucial part of the conjugal ties, it is usually registered in the husband's name and women often have access to it but lack control over such resources. Participants have also discussed cases where both sides of the family contribute equal amounts of money or property such as cattle, land, grain and domestic materials to the newlyweds. In the Amhara marriages of *Balikul* or *Equleta* (meaning equal contribution and sharing of properties between the couples) and in the Oromo, traditional marriages explained by men and women in Mudena Ibayyuu, there is a traditional agreement that in the dissolution of marriage both parties will leave with equal shares of the property. Specifically, women in Oromia noted that once couples are divorced or if the man marries another wife then the woman is entitled to half of the land

[39] The participant also noted that the cost escalation in dowry may be one of the reasons for abductions. Sometimes the boy and the girl might agree on abduction and settle the marriage through elders at a later date.

and she will be compensated with other assets. However, in a cultural context where women often lack autonomy and decision-making, land is registered in the husband's name and the men or elders decide upon women's fortune. Therefore, these agreements are at the discretion of the husband and community elders. These agreements can easily be denied by the husband and his families. In many cases, women will leave with nothing back to their parents or relatives.

Gender Identity and Marriage

Looking at gender identity and marriage will provide us the social context in which women become mothers. There is a cultural consensus that a girl becomes a "woman" when she is someone's wife and can bear a child. A young woman will transition from being a *Lijagered/Koreda* (female adolescent) to S*et woizero* (adult woman) in the Amhara context once she is married. In both Oromia and Amhara regions participants explained that adulthood or transition into adulthood is usually marked by the marriage or betrothal ceremony. No other ceremony is held separately for such transitions. Culturally when a young girl reaches puberty and experiences bodily changes, the community believes that she is ready for marriage and in other words ready for adulthood and childbirth.

Participants in both regions noted that a married woman is respected and accorded high value in society as compared to a woman who is not married. Hence the notion of womanhood is strictly tied to the institution of marriage and the ability to bear a child. Most women discussed the sense of pride and accomplishment they felt from being married. A woman in Andenet described marriage as follows:

> Marriage is pride. When you live with your parents you cannot be proud or you cannot earn their respect but when you are married, you have accomplished something, you have your own house even if you are not happy in your marriage your parents will respect you and they are proud of you so marriage is important. (Interview, Amhara, Andenet)

Women in these communities feel a sense of accomplishment when they fulfill this social tie even when they are not the ones arranging it or when they are not the ones consenting to it. Most women in both regions defined themselves and each other in the context of marriage. Emire (2009) in his study of the Amharic language focusing on Amharic proverbs and oral poems, asserts that the proverbs in the Amharic language glorify women's roles as wives, mothers and household managers. The exclusive sexual role of child bearing and pregnancy provides mothers with the highest respect in Amhara and Oromo societies.[40] Participants in both Mudena Ibayyuu and Andenet defined a woman's identity, sense of pride and self-worth mostly in terms of being a good wife and a good mother.

> A woman that can maintain her marriage and have children is considered a good woman. A lazy woman is the exact opposite. A good woman is also one that is hard working and has a good character. womanhood is defined based on how well a woman can prepare food, her skills can tell how good a woman is. (Interview, Oromia, Mudena Ibayyuu)

Various forms of marriages exist in both regions wherein women experience lack of autonomy and decision-making and where they also freely consent to some patriarchal structures of marriage such as polygyny in order to protect themselves from work burden

[40] Some of the proverbs from Emire's (2009) work depicting a mother's kindness and wisdom of wives include: A child without a mother is like a house without a dome. A mother's death is like sitting on an uncomfortable stone that gradually and slowly pains you. A mother is a prophet for her child. Wit/ Wisdom is to a woman as wonder is to a night. A woman's solution is like a fence full of thorns. (Emire, 2009, p. 59-60)

and reproductive duties. I will discuss here early marriage that is common in both regions and polygyny that is common in the Oromia region.

Early marriage is a very common practice in both regions. In Mudena Ibayyuu women married between the ages of 14-17 years of age while in Andenet Kebele women were married as young as 8 and the oldest age at marriage was 17 years old. Even though all participants were aware of the legal age for marriage, participants in the FGD and interviews explained that the practice of early marriage is still prevalent in Oromia and Amhara. In Oromia, the age at first marriage is relatively older (14) compared to the first age at marriage in Amhara which may start as early as birth. This reflects what the NCTPE nation-wide study has found in these regions in 2008. This shows that these practices are still prevalent in Ethiopia today. Amhara FGD and interview participants noted that some children are betrothed through a promissory marriage as young as 40 or 80 days after their birth, during their baptism and then parents wait until the children get older or reach puberty. If the relationship and the family ties are maintained the couple will start living together in their teens or when they are in their early twenties. Promissory marriages are unique to the Amhara community. There is a difference between promissory marriage or betrothal and marriages performed in later ages. Ideally children live at their parents' or in-laws' house until they grow in which case sexual contact or child bearing will be delayed until the girl reaches puberty or until couples start living together. However, participants noted that young girls are forced into sexual relations even when they are young. The youngest research participant in Amhara (19 years old) explained her experience as follows:

> I was married when I was eight years old. My parents celebrated with my husband's family and I stayed at home until I was ten years old. My husband wanted to take me when I was ten, I refused and I insisted on staying home. My husband was twenty something years old and he had informed my parents that he wanted children right away. I was too young for that so I was divorced after two years. Once I was divorced I wanted to go to school. My mother also agreed and sent me to school but my father disapproved and he used to hit me every day when I come back from school, saying that I was spoiled so I decided to not go to school. I was remarried at 16. It has been two years now since I started living with my second husband. (Interview Amhara, Andenet)

The young girl was married at a very young age and lacked the autonomy to decide or consent to her marriage. Unfortunately, this is the plight of many young women in Ethiopia who either wanted to pursue their education or delay marriage until a certain age or did not want to get married at all. Women who do not marry in both regions face a lot of social stigma. In Amhara, women who do not marry are considered to be acting out of their own will and they are said to have disrespected their families. Women and men in Amhara explained that if a woman is not married between the ages of 18-20, then she is considered late for marriage. Participants noted that the community calls them *"Dureye", "Galemota"* or *"Komo Ker",* meaning an old maid. Similarly, in Mudena Ibayyuu unmarried women are referred to as "*Meneteffte*", meaning the one who has remained at home with her parents. Similarly, women above 18 and those who are in their twenties or thirties are considered late for marriage in Oromia.

Rubin (1975) explains that in the "exchange of women" through marriage "women are in no position to benefit from their own circulation" (p. 37). Girls in both regions are married off at a very young age and often sent to live with their in-laws or with their new husbands. In both regions, men and elder women (her maternal kin or her in-laws) make most of the household decisions. Girls' autonomy is often limited due to

thier age. In addition, the literature in Ethiopia affirms that there is a large spousal age gap that may result in women's lack of autonomy and decision-making (NCPTE, 2008; Population Council, 2004). "The younger the bride the greater the spousal age gap, with an average of 10.1 years for girls married below the age of 15 years". (Population Council, 2004, para., 2). A participant in Mudena Ibayyuu explained her experience as follows:

> My husband was 10 years older than I was. I did not know my husband before we got married. I was afraid and sad that I was getting married to him. We (her friends and her) were all weeping because it was a day of separation and I was going to a family and a mother-in-law that I did not know. The day before the wedding, a bride is made to eat food mixed with the flour of herbal medicine called *"Fetto".* The meal has a laxative effect to empty the bowls. This is done to physically weaken the girl and reduce her resistance during her first sexual encounter and loss of virginity. I was given *Fetto* and I felt very weak during the first intercourse. (Interview, Oromia, Mudena Ibayyuu)

These conditions are tragic for numerous girls who wish to delay marriage, childbirth and pursue their education but are married off without their consent and are forced to discontinue their education and bear children (Gebre, 2012). In the event that a woman does not want to abide by these gender roles and wishes to continue her education, she will often be isolated and even banished from her home. This has been outlined as one of the major reasons for rural urban migration among young female adolescents running away from home in search of jobs or schooling (Gebre, 2012). There is a need to address such cultural challenges and protect women and girls' rights to delay marriages and reproduction and their rights to pursue their education. Oromo and Amhara women should be able to decide when and how to bear a child.

Many reproductive health interventions both nationally and internationally ubiquitously appropriate and take advantage of such unfortunate conditions to justify the

provision of family planning services, specifically provider-controlled contraceptives and sterilization. However, national and international reproductive health agendas often ignore the fact that many girls who migrate to urban spaces would prefer to stay home if they were afforded the right to education and the economic means while at the same time maintaining their social positions as wives and mothers in their community.[41] The notions of womanhood, as tied to marriage and child bearing discussed above, are the ways in which most Amhara and Oromo women (both rural and urban) value themselves and each other in their society.

Polygyny

Another form of marriage common in Oromia is polygynous marriage where a man marries more than one woman. Studies in Ethiopia and elsewhere have documented the sexual and reproductive health concerns, power dynamics and property ownership issues women experience in the practice of polygamous marriages, particularity among Arab and African nations **(**Bove &Valeggia, 2008; Gibson & Mace, 2007; NCTPE, 2008). Polygamous marriage is not afforded legal recognition in the family code of Ethiopia, however based on the interview and FGD responses of participants and other nation-wide studies, the practice of polygyny is common in Oromia (CSA, 2012, NCTPE, 2008). A man can marry up to three or four wives depending on whether he is affluent enough to provide for all of them. Participants noted that a polygamous marriage often takes place when one of the following conditions occur: when there are no children born

[41] Informal discussion with rural migrant domestic workers in Addis Ababa. Also, the population Council has a project called Biruh Tesfa that works with migrant domestic workers. http://www.popcouncil.org/projects/41_BiruhTesfaSafeSpaces.asp.

in the first marriage, or the husband has work or a house in another locality or when there is work burden in the household that the first wife or family cannot bear. One woman explained that "people marry to live together and to work together". It is important to note that these marital unions often are patriarchal and in most settings oppressive to women. Some women for instance have explained their dissatisfaction in polygynous marriages due to lack of autonomy to decide about when to have children and the number of children. They also noted their lack of control over property ownership. Property is often in the hands of the man and at his discretion.

On the other hand, the discussions I have had with women in polygynous marriages both in the FGD and in the interviews present a complex situation that challenges the view that women are passive victims in these patriarchal settings. It also challenges the universalized development and reproductive health research and program assumptions that polygamous marriages are almost always imposed on the women involved in these arrangements. Women and men noted that women also exercise autonomy in these marriage structures and are in many ways the initiators of these unions.

A woman in a polygynous marriage explained that she asked her husband to marry another wife so that he can have children with the second one and because they required assistance in house and field work. She explained how she willingly organized the wedding ceremony for her husband. She also noted that she discussed marital arrangements and wealth distribution with the husband ahead of time. As we will see in the next section, in Oromia, polygynous marriages restore the respect women have lost due to infertility through the process of adoption of the child of the second wife. Women

also use these arrangements when they no longer wish to have children. In describing Nego-feminism Nnaemeka (2004), notes that women employ different strategies to deal with patriarchal structures, through resistance and negotiation. Oromo women in this study who are engaged in polygynous marriage arrangements are making conscious decisions to deal with the challenges of patriarchy in a monogamous marriage through a polygynous marriage arrangement. They are also making an economic decision to collectively share the burden of traditional farming and household work. A 63-year-old man in a polygynous marriage explains his experience and interaction with his wives as follows:

> I got married at the age of 22 and my first wife was 17 years old. Now I have 18 children, 13 from my first wife, and 5 from my second wife. The two of them [his wives] know and respect each other. In fact, my first wife who gave birth to 13 children was the one who suggested that I take a second wife because of the pressure of work and responsibility on her. They do not live together. One is living here and the other one lives in Tulu Bolo [a nearby town]. When my second wife comes to visit, I sleep with the older/senior wife and the younger sleeps in another room with the children. (Interview, Oromia, Mudena Ibayyuu)

As evident in this account a power hierarchy based on age exists between the first wife and the other wives. Usually the first wife is highly respected both by the husband and the other younger wives. The power dynamics among women based on age and experience also needs to be examined and further studied when addressing women's health and wellbeing in a polygynous marriage. The above-mentioned social relations and the context of polygynous marriage arrangements are not considered in international and national development and reproductive health programs that often design programs for monogamous couples using a western nuclear family model.

Overall, a deeper understanding of the need for family ties and kinship in the context of marriage, the different types and contexts of marriage and the economic purpose of marrying children off at a very young age will help the government design appropriate and context-specific strategies. In addition, the tradition of delayed marriage after long betrothal or what they refer to as "eating together" can be used as an entry point to encourage communities to further delay marriage while still maintaining the kinship, familial and economic ties that communities want to preserve. Also, addressing the economic problem and poverty women and their families reside in may greatly reduce the effect early marriage has on the lives of young women. Moreover, examining the dynamics in early and polygynous marriages is significant to avoid a universalized assumption about these practices and to address complex circumstances within these arrangements through heterogenous and comprehensive maternal health solutions. In addition, legal enforcement although necessary in certain contexts does not seem to be effective in delaying marriage or stopping men and women in the community from performing customary marriages. As discussed above, both men and women were aware of the legal age for marriage. In the beginning of our discussion most women and men would talk about the legal age for marriage and how things have changed now. However, with further probing and mostly in the FGDs participants acknowledge and discuss that early marriage is prevalent in their area. Their reluctance to share this information is mostly due to their fear of imprisonment.

Fertility and Infertility

As mentioned earlier marriage is often immediately followed by pregnancy and communities pressure married couples to have children in the first two years of marriage

(NCTPE, 2008). Related to the context of marriage and to understand the reproductive desires and needs of women in both regions, I asked participants about what it means to have children for Amhara and Oromo women and their communities and the number of children they currently have. Number of children that interview participants have in Amhara ranged from two to seven while in Oromia participants who have children had from three up to eighteen children per household. Some participants also mentioned that they have lost children in between and that this has been a motivation to have more children. The desire to have children for social connection and continuity is an essential part of the gender constructions of Amhara and Oromo women. Women from both regions also noted that the ties of marriage are further strengthened when children are born.

Women and men in the interviews and focus group discussions of both regions explained that one of the primary purposes of marriage is to have a child. A woman from Andenet Kebele in Amhara explains the honor, legacy and social connection that results from having children, particularly for women as follows:

> Especially for a woman it is gives her a sense of pride. You will be invited to social gatherings; you will be respected among the elders of the community. Also, when parents pass away, it is children that will take over their land and other assets and they will protect and maintain the family legacy. (Interview, Amhara, Andenet)

Similarly, women and men in Mudena Ibayyuu discussed the purpose and role of children in marriage and their lives. A woman in Oromia explains the philosophical meaning and significance of having children in the Oromo society as follows:

> As you know, Oromos love children. There is an Oromo saying *Qorrichi Da Elmo Da* which means "The medicine for death is having children". This is to say that, although one's physical existence ends with his death, his children and their

> descendants will bear witness to the fact of his existence once upon a time. (FGD, Oromia, Mudena Ibayyuu)

Women and men in both regions pointed out that in addition to continuing the family legacy and honor, children are a source of labor and social support. Women noted that a person who has children is a person who has support at home. When parents or guardians grow old, children look after their parents. Participants in both regions explained that they do not have an established formal social security system in the rural areas, hence children look after their parents and their assets when they are no longer able to take care of themselves.

> Children help their parents. Those of us who do not have children, we spend our day running around the house. It is important to have children. Also, it is when we have children that we will "bow our heads" meaning stay faithful and together. He will stay faithful if we have children. (Interview, Amhara, Andenet)

As mentioned earlier studies elsewhere have documented families' reasons for wanting large numbers of children in third world nations and specifically in Africa (Hartmann, 1995; Dyer, 2007). Dyer (2007) explored the motives of parenthood in the African context from a textual analysis of 35 infertility studies from different African countries and found similar results. The value of children and their importance in a wide range of societal relationships is explained in these studies in relation to the consequences of infertility. Consequently, in the findings of these infertility studies, marital ties are preserved and secured as a result of women having children. Children are often valued as a source of honor, social security, and source of labor. Children secure the property and inheritance rights, particularly for women in the context of Africa. They also maintain family lineage and satisfy emotional needs of the parents. Dyer (2007) concludes that

parenthood has more and arguably deeper roots in African communities when compared to industrialized nations. Hartmann (1995) also highlights the conditions in the third world where children are a source of survival, security and power (p. 6 &47). Dyer's (2007) and Hartmann's (1995) discussions resonate with Oromo and Amhara women who are valued in their society because of their children and are able to retire when their children are able to look after them. Socio-cultural ties and economic conditions are major reasons for having large number of children. However, local and global population and reproductive health policies that mainly focus on fertility reduction and family planning services do not address these reproductive needs of women.

The Ethiopian Reproductive Health and Population Policy have so far not addressed the social consequences of infertility. Many studies elsewhere have noted the social devastation and stigma women experience due to the inability to bear children (Dyer, 2007). In my previous study of obstetric fistula and its impacts on women's lives, the women I interviewed from Amhara, Oromia and Tigray (another region in Ethiopia) informed me that being unable to bear a child or not being able to marry again[42] after the occurrence of obstetric fistula was more painful socially and psychologically than the physical pain they endured, as they no longer would be valued and respected in their community.

However, regional variations exist in how women are treated in their respective communities. In Amhara, if a woman is unable to have children, she is often ostracized by her community. Women are called names such *Beklo* (literally meaning a Mule) for not being able to accomplish what their mothers and other women have in their

[42] Often the previous marriage ends in divorce or separation after the occurrence of fistula (Girma, 2008).

communities are respected for. Infertility remains a high-risk factor for divorce in the context of Amhara. In most cases families push the husband to marry another woman to get children. The woman is often sent back to her parents.

> A woman who cannot give birth is not respected in the community. If she attempts to seek help from other people's children, we say she should have her own to order around. If women stay longer than two years after marriage, we say "*Mehan honech*" or she is infertile and her husband is advised to remarry (Interview, Amhara, Andenet).

Oromo women and men seem much more accepting of women who are infertile than Amhara women and men. In the Oromo culture a woman or a man who is unable to bear a child is called *Maseena* (infertile). In the FGD and in the interview women and men expressed that people are sympathetic towards women who are not able to bear children. In marriage if the woman or the man is unable to have children in most cases they agree to adopt a child (from the tribe) according to the Oromo custom of *Gudi Fecha*. They bring up the child as their own and the child will be the lawful heir. The other alternative is the polygynous marriage arrangement where the wife allows the husband to marry a second wife. If a child is born, then the husband will give the child to the first wife through *Gudi Fecha* to raise as her own. This is done so that the woman is able to have an heir and so that her wish to have a child is fulfilled. Also, relatives may give a child to the woman to raise as her own. The child will be called in the woman's family name. A woman in Oromia discussed her experience as follows:

> My husband and I were married when we were young. I was not able to have a child. I felt very sad that I was not able to have one and was afraid that my in-laws will be disappointed. My husband although he has great love for me was advised by his parents to marry another woman. I cried at first and I was very disappointed. I decided to leave. Now I have my own land and I have a son that was given to me by my cousin. (Interview, Oromia, Mudena Ibayyuu)

The above social structure of *Gudi Fecha* provides women with the opportunity to be mothers and to perform the gendered identity women earn respect and value from in their communities. Participants in Oromia also noted that if the woman does not want to be involved in a polygynous marriage, she will leave the marriage with her share of property and the man remarries.

In both regions, families in most cases push the husband to marry another woman to have children. Usually it is the families that advise the husband to marry again. Parents or in-laws' views about infertility vary remarkably depending on whether it is a man or a woman who is infertile and whether the advice is coming from the parents of the woman or the in-laws. Participants in both regions discussed that the advice they give to their children when issues of infertility arise would vary depending on whether it is their son or daughter who is unable to have children. If it is their daughter who is infertile, she is at the mercy of her husband and her in-laws. However, if it is their son who is married to an infertile woman parents will encourage the man to remarry. In-laws and parents hardly ever advise a woman to re-marry demonstrating the gender bias in the advise families give to men and women with fertility issues. A woman in Oromia explains as follows:

> If I was faced with such a situation involving my son and my daughter, my decision will not be the same. If it is my son, I will advise that he take another wife. If the childless woman was my daughter, I would not support the idea of her husband marrying another wife. However, if it is my son's wife I will advise him to marry another woman. (Interview, Oromia, Mudena Ibayyuu)

The national policies of the nation do not properly address socio-cultural factors of fertility and infertility. As noted in chapter three, the National Population Policy and the National Health Policy hardly discuss women's desire and need to reproduce. When fertility is discussed it is often addressed as a population growth problem. Issues of

infertility do not exist in policy documents and in reproductive health implementation strategies. This is a huge policy gap that the government needs to address if it is to address women's reproductive and maternal health needs. The lack of attention to women's fertility desires and needs is mainly due to the nation's overall focus on family planning and facility-based delivery as the only solutions for maternal health concerns. Maternal health in accordance with the ICPD definition of reproductive health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system." (WHO, 2008). [43] Therefore, the National Reproductive Health Policy and the Population Policy need to address the social and mental wellbeing of women in the context of both fertility and infertility.

Religion

Ethiopia is a country known for its long history of statehood and religion. The most dominant religions are Orthodox Christianity and Islam, while the Catholic and Protestant faiths also have sizable followers (CSA, 2012). Religion plays a dominant role in the lives of individuals and communities in Ethiopia. But the nature of the influence varies with the cultural and historical context and different localities of the country. For example, in the northern part of the country covering the Amhara regions of Gojjam,

---

[43] WHO. (2008). *Integrating poverty and gender into health programmes: A sourcebook for health professionals (Sexual and reproductive health).* Retrieved from http://www.who.int/gender-equity-rights/knowledge/poverty-gender-in-health-programmes-sexual-reproductive-health/en/

Gondar, Wello and Shoa as well as the region of Tigray, the influence of Orthodox Christianity is very strong (see Appendix B for maps of the nation and the regions). In the southern part of the nation including the region of Oromia, Protestant and Orthodox Christianity, Islam and other traditional beliefs are prevalent. The majority of the respondents in both the interviews and FGDs identified as Orthodox Christians and only one of the participants from Oromia identified as Muslim. In both regions, I asked questions aimed at gauging the degree of influence priests have specifically in relation to marriage, childbirth and family planning practices for individual respondents and for FGD participants.

Religion plays a significant role in marriage and childbirth in Amhara communities. In the tradition of the Orthodox Christian Church, every family (at least of the older generation) is supposed to have a religious father or a priest as *Ye Nefese Abat* (Father of the Soul). Generally, priests are held in high regard and reverence. FGD participants noted that the people listen to everything priests say and that they look up to them. They pointed out that the community might be reluctant to listen to other authorities, but when things come from the priests, people obey without qualms. FGD participants added that priests in Andenet are arbitrators in matters of theft, crimes, armed robbery, disruption of land boundaries, domestic violence and disrespect towards elders and non-observance of religious holidays and ceremonies. Most Amhara communities have a close connection with their priests as most family members go the church every Sunday for mass and during the celebrations of the Saints' Days. The priests are that ones that perform marriage ceremonies in the community and generally promote monogamy

and fidelity. Participants pointed out that marriage does not take place without the approval and blessing of priests.

> The priests are the religious leaders around here. A marriage does not take place without their presence. A marriage without a priest's blessing is not considered marriage at all. They are there to bear witness and officiate the marriage. They also give advice on marriage and on how to be good parents and raise our children. Priests either attend and approve of the marriage or they denounce them… (Interview, Amhara, Andenet)

In some cases, marriage ceremonies are held in church where the couple takes Holy Communion- *Kurban*. In such a marriage divorce and remarriage are considered sins. The priests also exercise their influence by visiting the homes of their "Spiritual Children", conducting prayers, blessing the members and sprinkling the house and the people with holy water. Specifically, after childbirth, on the 10th day, the priest comes to pray for the wellbeing of the mother and the child, and sprays holy water to cleanse the house of evil spirits. In addition, the priest officiates important occasions such as the baptism of a baby, prayer and blessing of the feasts prepared to celebrate baptism, wedding and the occasion to commemorate anniversaries of deaths.

Participants noted that most priests condemn the use of family planning in Amhara. The priests view the use of family planning as an act of sin that will lead to eternal damnation. Due to their influence in the community, this may be part of the reason why some women do not use modern family planning services. A woman in Amhara noted that the reason she does not want to use family planning is because this is not what God intended and because she does not want to limit her fertility in "unnatural ways". Another one explains her experience as follows.

> I have six children: two girls and four boys. I still want to have more children. I have not used any family planning so far and I do not intend to do so. Father

> (priest) has told us that it is a sin and that it will take us to hell. So I don't want to use it, I am afraid to use it. (Interview, Amhara, Andenet)

Even though some women consider modern family planning practices as an act of sin, it is important to note that many Ethiopian women who are Orthodox Christians for many years have been secretly using traditional birth spacing methods, herbs and traditional medicines that they consider natural to prevent pregnancies (Kassaye et al., 2006; Mehari et al., 2012). Hence, perhaps the reluctance to use modern family planning methods is not the rejection of the practice of limiting or terminating pregnancy itself but rather of the modern form it has taken. As we will see in the next section women often use family planning despite society's pressure and influences of religion.

Conversely, some priests in the Andenet FGDs have mentioned that they are very much involved in promoting modern family planning, the health campaign of "Zero Home Delivery", and the banning of TBAs. A priest in the FGD mentioned that they have been ordered by health officials to inform TBAs not to provide their services. "We have advised Traditional Birth Attendants to stop practicing as ordered by the health authorities. Because they are not using gloves etc." This indicates the effort of development agencies (government and NGOs) to involve elders, religious leaders and other influential members of the community in sensitization and awareness creation activities. Any form of intervention in Amhara related to marriage and maternal health should indeed include these community members in designing appropriate reproductive health programs. However, the type of intervention and the programs that match the needs of the women they serve are not being promoted. Priests and government health

officials are therefore promoting the elimination traditional birth practices and TBAs practices upon which women rely.

The experience of Mudena Ibayyuu participants in Oromia is quite different from that of Andenet Kebele participants in Amhara. The influence of Orthodox Christianity on marriage and childbirth in Oromia region is rather insignificant even though all but one stated that they are Orthodox Christians. From the interviews and FGDs in Oromia, it was possible to see that the bond between the priests and laity was not as strong. The participants said that they go to church occasionally and on Saints' Days and other events such as baptism and burial ceremonies. Otherwise, the priests are not involved in teaching or advising about issues of marriage, health or childbirth. A man in the FGD notes

> They [priests] only preach about Christian life. About doing good, respect for each other and peaceful life etc. Apart from such teachings, they do not instruct us about marriage and childbirth. (FGD, Oromia, Mudena Ibayuu)

Priests and Christianity have less influence among the Oromos because Orthodox Christianity is a foreign religion to Oromo culture and history (Deressa, 2003). Christianity was adopted through assimilation, internal territorial expansion and the domination of the Christian highlanders from the North and Oromo expansion from the South West (Deressa, 2003; Legesse, 1973). Oromos have their own religious belief and a well-developed social and political structure called the *Gadda* System they employ along with their adopted faith of Christianity. The Supreme Being they hold in high regard is called *Waaqa* or *Waaqayo/ Waaga Guuracha (the Black God)*[44] *(*Kelbessa,

[44] "Oromos." Junior Worldmark Encyclopedia of World Cultures. Retrieved March 18, 2017 from Encyclopedia.com: http://www.encyclopedia.com/international/encyclopedias-almanacs-transcripts-and-maps/oromos

2013). In their religion Oromos do not believe in the concept of heaven and hell and eternal damnation.

According to the study participants there is a female Goddess *Atete* that they call upon for good fortune, fertility and wellbeing of women and their children. Usually it is the women who officiate the ceremony and the spirit of *Atete* is believed to talk through the woman of the house that conducts the ceremony. In *Atete* ceremony family and neighbors prepare special oatmeal seasoned with butter and sweet smelling grass, bread and traditional beer called Tella. The necklace made of colorful beads called *Challe* that the woman wears during the ceremony symbolizes the guardian spirit of the Goddess. Apart from other occasions where *Atete* is invoked and celebrated, when women are in labor or there are infertility issues, Oromo women in this area call upon both *Atete* and the Virgin Mary to help the woman who has maternal health problems. Legesse (1973), in a well-documented analysis of Oromo socio-cultural and political system in Borana, also noted that most spiritual rituals of Oromo women are related to their fertility since Oromo women value having children above all else (Legesse, 1973). Both FGD and interview participants claimed that they simultaneously observe and practice the above mentioned traditional, religious rituals of the Oromo culture even if they have identified themselves as Orthodox Christians. In addition, even if they are Orthodox Christians the practice of polygyny is very much prevalent in Mudena Ibayyuu.

Our understanding of the influence of religion in both regions and the different forms of beliefs that influence women's decision to have children and to use family planning is crucial in developing maternal health programs that are context specific and culturally contingent. For instance, a reproductive health program that simply targets

dominant Orthodox Christian priests in Oromia region might miss the traditional religious ceremonies headed by women that are significant in their decision and practice of fertility and child delivery.

Family Planning Use

In chapter three my discussion of family planning was specifically related to how the National Health Policy, National Reproductive Health Strategy and the Population Policy have addressed the issues of fertility and family planning. In this section I discuss actual family planning practices of women in Andenet and Mudena Ibayyuu Kebeles. As mentioned earlier provision of family planning services is a major priority of the nation. Health posts are the nearest health facilities in the Kebeles and family planning is widely available and free in all health posts in both regions while basic and emergency obstetric care are non-existent. In addition to the first-aid services HEWs provide at the health posts, they mainly provide oral contraceptives and injections (Depo-Provera) and they also administer Implanon (a 3-year, long-term hormonal conceptive implant placed in women's arms). However, the HEWs in both regions have noted that implants are generally administered in the Health Centers that are found in the nearest towns.

Currently out of the thirty women total (twenty women directly interviewed and the ten wives of the men interviewed), nine women have used or are currently using family planning services. Out of the nine women who use family planning three take injections and one uses implants in Oromia while two of the women use implants and three take injections every three months in Amhara. The majority of women who do not use modern family planning have cited side effects and fear of infertility, religion and

traditional birth spacing methods (periodic abstinences, lactation and coitus interruptus) as major reasons for not using modern family planning methods.

> I currently do not use family planning because I am afraid that I will get sick. I hear a lot of women complaining about having mood swings. They say *yakewesal* [literally meaning it makes them crazy]. They also complain about physical pain and losing a lot of blood. Even though I do not want to have children, I am afraid to use these methods. (Interview Amhara, Andenet)

> I do not want to get sick since I am a farmer and I need to work hard every day. So, I leave it to God and keep having children. But I do not want to have children anymore. I used to wish to have four children; I have four of them now. (Interview, Oromia, Mudena Ibayyuu)

All women both users and non-users were aware of the availability of family planning services. However, all users in both regions noted that they were not informed about side effects prior to the administration of the family planning methods. The recent national demographic and health survey (DHS) shows that out of the women using family planning methods only 28 percent of current users of the pill, IUD, injectable, or implants were informed about potential side effects of their method; 24 percent were told what to do if they experienced side effects; and 37 percent were given information about other methods (CSA, 2012). The common experience in both regions is that women go to health posts and health centers once they have started experiencing side effects. All women who are currently using family planning except for one in Amhara have experienced different forms of side effects[45]. Common side effects explained in Amhara

[45]The woman who did not experience side effects explained her FP experience as follows:
I have used family planning before. I have four children 3 girls and 1 boy and I don't want to have any more children. I took the FP from Arabit, which is about 2 hours walk from here. I used Depo-Provera and I also used pills and both worked fine for me. I did not experience any side effects. I have taken it for three years. Soon I will give birth to my little one and once I am done breast feeding, I will go back and start using family planning. (Interview, Amhara, Andenet)

and Oromia from the Depo-Provera shots and the Implanon include bleeding for months and over a year (anemic), dizziness and light headedness, numbness and pain in the arm where the Implanon is inserted, hair loss and being unable to bear a child after stopping long-term family planning methods.

> I have heard a lot of people getting sick. My husband's sister is very sick she used the one they put on the arm. Also I have heard of women who could not bear children after they have used the injection. But we have no choice for the time being so we use. (Interview, Amhara, Andenet)

> I have also heard that there are women who have used long term FP methods such as Depo-Provera who have become infertile. I know of a woman who has been ostracized and who is gossiped about for not wanting to have children deliberately when in fact they have stopped taking the shots and have been trying to conceive. She is my friend and we socialize and drink coffee together. (Interview, Oromia , Mudena Ibayyuu)

Health professionals in both regions also noted the side effects women discussed above. However, some of the healthcare professionals believe that what women report as side effects are a bit exaggerated or something that women have heard from neighbors and they worry that informing new users in this area of the side effects would discourage use of these services. Specifically, one of the HEWs downplayed side effects as misinformation or rumors women have heard in their neighborhood. These attitudes reflect the local development and modernization assumptions of health professionals that I elaborated in chapter three. The construction of rural women as ignorant passive recipients that need guidance and regulation and that often lack knowledge and information is quite prevalent in this context. Women's concerns are dismissed as rumors and exaggerated side effects. Withholding information about the consequences of the methods and simply assuming that the side effects are exaggerated rumors shows the gap

between family planning service provision and women's family planning needs. Such assumptions simply put women's lives in danger.

It is imperative that women have a wide range of options of contraception to choose from, and that they are able to make informed decisions about long-term and short-term family planning methods that they intend to use. However, the family planning information and education third world women often receive is encouragement to use provider controlled long-term family planning methods (Takeshita, 2012). The long-term provider controlled methods -Injection (Depo-Provera) and Implants- that health professionals currently administer and highly promote in both Kebeles of the Amhara and Oromia regions have either been banned or discouraged from different western nations for their potential harm. The FDA has added a "black box" warning about the harm and threats that result from the long-term use of Depo-Provera. The FDA made its recommendations based on the substantial amount of research that showed connections between its administration and low bone density, anemia, increased risk of cancer and increased risk of HIV (Oas, 2015). While WHO and other health professionals that market this product to third world nations have strongly argued for the removal of this warning, the FDA has recently insisted that the health risks outweigh the benefits. Similarly, courts in the UK and Australia have banned Implanon after many women complained that it disappeared in their arms where it was inserted making them indefinitely infertile (Randhawa, 2011). The potential harm could be even more devastating for women in rural areas whose social and economic conditions further expose them to infirmities. Therefore, women in Amhara and Oromia are not exaggerating their conditions. On the contrary, they have made informed decisions not to

use dangerous methods based on what they have experienced or what they have seen and heard from relatives and neighbors. This is the challenge of making the right choices in the absence of appropriate information from healthcare professionals. In addition, it also unfortunate that women who want to limit their fertility have no other option but to use these highly harmful hormonal drugs to limit their fertility. This again is related to global and local population control programs underway to limit third world women's fertility at any cost.

Interestingly the nurse who administers family planning services in the health center in Seden Sodo Woreda, Oromia explained that she informs users of the various side effects before administering the implants or injections and that she attentively documents the side effects women experience. Her account of the side effects resonated with women's concerns that I have noted in the community. She also noted that Norplant, another long-term provider controlled implant that has been banned in other parts of the world, was being administered up until two years before she started working at the health center in 2013.

Another crucial concern HEWs discussed is their lack of experience of administering Implanon. The HEW in Oromia mentioned that she has been trained on how to insert Implanon for women but said that she does not have the experience on how to remove it. Women complained about traveling to health centers (4-6 hours) to have them removed. In addition, it costs women money to have implants removed or to address side effects. This situation is quite challenging for women who often do not have autonomy to decide on financial resources or who may be using family planning services without their spouses' knowledge. An interview participant explains as follows:

> Yes, I use the injection that lasts for three months (Depo-Provera). I have used it for about a year. They (health care professionals) ask me to use the one they put on your arm but I refused because I have heard that women were having difficulty working and doing their daily chores especially around fire. The three-month injection is working well but I feel light-headed and I have not been menstruating for about a year. I said I will go for checkup but you know the injection is free, the checkup is not. It costs money to check your blood, urine etc. (Interview, Amhara, Andenet)

This discussion of family planning services points to three main things. First, the government's priority to increase contraceptive prevalence rate is actively pursued in these regions. Second, there is a gap in the family planning information and services provided. Finally, rural Ethiopian women do want to use family planning services to either space pregnancy or limit their fertility once they have had the optimum number of children that they want. Women's conscious decision to limit their fertility in a socio-economic context where children are highly valued primarily disproves the population control narrative that third world rural women are unable or unwilling to control their fertility (Hartmann, 1995; Takeshita, 2012). The fact that health professionals downplay the side effects and risks of hormonal family planning drugs and women's health conditions compromises women's health and trust in the health care system and health care professionals' relationships with the community. Thus, many women will continue to avoid family planning despite their need and desire to limit their fertility.

Women demonstrate their agency and resistance from their socio-cultural subordination in how they exercise their reproductive health choices despite religious and gendered pressures from their communities. Some women decide to use family planning even though their religious leaders and their families compel them not to do so. One example that I would best describe as women's subtle but successful resistance from such

pressures is my encounter with a 19-year-old interview participant who is an elder priest's wife. Despite the constant interruption from her mother-in-law who lived next door and specifically instructed me not to give her daughter -in-law any form of family planning, the young woman decided to sit and discuss her views. The participant informed me that she was forced to get married at the age of 15 and had her child when she was 16 years old. Since she was married to a priest there was no way that she could openly use family planning. She thus secretly went to the health center to have an Implanon inserted as she did not want to have another child. She did not inform her in-laws or her husband that she was going to the health center but she informed them that she was going to her friend's house. Her friend accompanied her to the health center. In difficult circumstances, women establish and rely on informal networks to resist societal pressure. Hence women in these contexts are not ignorant passive recipients but rather are informed decision makers amidst challenging circumstances.

Childbirth Practices in Amhara and Oromia

Local practices of childbirth before, during and after delivery are another social dimension of maternal health worth examining. Few studies on childbirth have documented the detailed process of traditional childbirth. Most of these reproductive health studies have focused on the reasons for delivering at home (Bedford et al., 2013; Kaba et al., 2016; Roro et al., 2014; Shiferaw et al., 2013). Specifically, there are few studies that have inquired about women's choice to deliver at home or have explored the cultural practices during pregnancy and childbirth from the perspective of women and their community (Bedford et al., 2013; Roro et al., 2014; Shiferaw et. al, 2013). National surveys have not examined the various social dimensions that influence women's

decision to deliver at home or why and how women give birth in such situations (CSA, 2012; FMOH, 2006). The discussion and description of these practices are crucial to establish context specific and culturally contingent solutions. As noted earlier the majority of Ethiopian women still prefer to deliver at home despite the policy push for facility-based delivery (Kaba et al., 2016). Therefore, it is significant to understand why women deliver at home and the actual process of childbirth that takes place there.

Childbirth is a joyful event in Amhara and Oromo women's lives. It is a moment where women earn respect and fulfill the society's expectation of womanhood and motherhood. It is a moment where they create lineage and legacy in their socio-cultural context. Therefore, childbirth and motherhood are among the most celebrated events in Ethiopian women's lives.[46] Both traditional and religious views influence the overall process of childbirth from pregnancy until the postpartum period. For Amhara and Oromo women, the birthing process is considered a natural and "healthy" process that does not require seeking health services. From the interviews conducted with women in both Amhara and Oromia, it is clear that women seek health services as the last resort when there is some sort of illness or emergency during pregnancy and childbirth.

> First we try to delivery at home and then if a problem arises we go to a health facility. Most women around here would prefer to deliver at home. That is what we want. (Interview, Oromia, Mudena Ibayyuu)

Of the women interviewed in Oromia only one stated that she gave birth to one of her children in the health center while the other fourteen were delivered at home (this is including the wives of the men interviewed). Also, in Amhara out of the fourteen women

[46] A prominent Amhara King took a term of endearment for a mother (*Emye*) as a title Emye Menilik depicting high regards and respect a mother has in national ideals at large but in the Amhara culture in particular.

who have children only two stated that they gave birth to one of their children in the health facility. The women who have gone to health centers except for one in Amhara all noted that they tried to deliver at home first and then went to the health center when labor was obstructed. Other recent studies conducted in four regions of the nation also confirmed the reasons women gave for not seeking institutional delivery including the belief that it is neither necessary [as childbirth is natural] nor customary (Kaba et al., 2016). Moreover, during pregnancy women, specifically in Amhara region, are supposed to cover their bellies in public until they give birth for fear of harm from bad/evil spirits (*buda*) (Hannig, 2012). Therefore, it is not customary to reveal one's body and show one's belly to a stranger such as a health care professional. Thus, even though health facilities are close by, women may not attend due to their socio-cultural practices. Reproductive health programs and policies have rarely attempted to understand or address these beliefs and traditions (Kaba et al., 2016; Shiferaw et al., 2013). Other reasons mentioned are the distance to health facilities and lack of public transportation and unavailability of roads. These reasons are addressed in chapter five along with the possible recommendations and community engagements underway. Position of delivery and social comfort were additional reasons women mentioned for their preference to deliver at home. The women in Amhara and Oromia noted various preparations made prior to delivery and the social comfort and support they have at home. A woman in Amhara explained the comfort traditional laboring and delivering on the floor as follows:

> We do not deliver in bed, one quintal sack of grain is covered with cloth and it is laid on the floor and the pregnant mother lays there and gives birth. It is comfortable and easy to push on the floor. After she delivers, the area is cleaned then she is moved to the bed. (Interview, Amhara, Andenet)

During labor and delivery women relatives and family members together with the TBA assist the woman and provide the necessary social support. In addition, women are accustomed to preparations and social gatherings and feasts prepared after childbirth that are not provided in a health facility. A recent study in four regions of the nation has confirmed that one of the primary reason women prefer to deliver at home is that the health facilities are not comfortable spaces for women (Kaba et al., 2016).

I discuss here the process and preparation before, during and after childbirth in Amhara and Oromia. The women in both regions noted that before delivery, the woman's mother, sisters and other female relatives prepare food and the household for the postpartum period. Since women will not work both inside and outside of the house until they recover from delivery, food items and necessary materials are prepared ahead of time. These women in addition to the psycho-social support they provide for the pregnant woman also help in the preparation of food materials such as *berbere, shiro,* butter, wheat and barley that are used to prepare porridge called *Genfo* after delivery. These women also are the main source of information and knowledge about pregnancy and childbirth for the pregnant woman. These food preparations may take up to three months. It's the time for celebration and joy where women gather to have coffee ceremonies, sing and comfort the pregnant woman. Amhara and Oromo women rely upon these women as social support in times of pregnancy and delivery. Reproductive health programs could benefit from engaging these elder women in sharing information and education about clean and safe home delivery to pregnant mothers using their traditional gender roles in the process of childbirth.

When labor has started the woman and her female relatives will prepare butter, a razor blade, clean receiving cloth and water for the delivery. They will also summon the TBA who will assist the woman in the delivery. Participants in Oromia and Amhara explained that TBAs might live far but families still travel far to call TBAs first instead of going to the HEWs or to the health facility. This speaks volumes in terms of the trust and value attached to the practices and services of TBAs. One of the challenges of home delivery is prolonged and obstructed labor that often lasts for days and in many cases, results in the death of the child or woman, or in other maternal health complications such as obstetric fistula[47] (Girma, 2008). Therefore, understanding the local process of childbirth when labor is prolonged is particularly significant in designing reproductive health programs that allow women to deliver at home in a safe manner and to also detect complication early in order to go to the health facilities in a timely manner. When labor is prolonged various rituals take place from belly massages with butter and *Simbul* (cream prepared for massage), to giving the pregnant woman flaxseeds and other local beverages made from different herbs, keeping her warm, fumigating the room and most importantly praying. These rituals are carried out by the TBAs and the female family members. The flaxseed is believed to ease bowl movements and discomfort in the stomach and other herbs such as garlic, ginger, *tendadam* and others are used for pain management.

However, prayer and spiritual rituals are considered the single most important solution in these circumstances. An FGD participant in Amhara said "If labor is prolonged the first thing we do is pray. The women and mothers carry stones and pray to

[47] Obstetric Fistula: Is an opening between two adjacent organs usually between the vagina and the bladder or the vagina and the rectum or both because of prolonged obstructed labor. The woman becomes incontinent of urine or feces or both (Girma, 2008).

Mary to forgive the mother" (FGD, Amhara, Andenet). In Amhara, prolonged labor is considered a wrath from Mary (the mother of Jesus). Both men and women of the family pray to Mary, asking her to have mercy on the mother and the child.[48] In Amhara the fumigation is believed to drive evil spirits away. If the mother has lost a lot of blood and she has become unconscious, the family will take her outside of the house and fire their weapons in an effort to help her regain consciousness. This is called *Serakain.*

The FGD discussants in Oromia noted that when labor is prolonged, everyone in the room, women and men alike, kneel holding freshly cut grass in their hands and pray for the Virgin Mary to show mercy and protect the mother and bless her with safe delivery. Sometimes, when the labor is difficult, a young girl is made to carry a yoke and everybody will pray for the safety of the mother and the child. The women's prayer may also involve the *Atete* ceremony from the Oromo spiritual tradition where the women in the family beg the Goddess for her help. A woman explained her experience of labor as follows:

> Labor was so difficult and it lasted more than two days. All family members and villagers (male and female) were worried and prayed together for the Virgin Mary to spare my life and help me to deliver safely. The prayer also involved a virgin boy and a girl who carried a yoke on their shoulders and green grass in their hands as they begged for safe delivery. Luckily my child and I survived. (Interview, Oromia, Mudena Ibayyuu)

Another thing that women do in both regions during labor is make coffee. Daily coffee ceremonies are unique social spaces women engage in for social support, rest and connection. During labor, however, coffee is used as a spiritual prayer and plea to the deities.

[48] This is why when a woman gives birth in Amhara, people greet the mother with "Enquan Mariam Marechish" meaning "thank the lord that Mary had mercy on you" as a formal greeting to the mother.

> We prepare coffee during delivery and it is like a prayer to Mary. If she does not deliver in the first instance, then women take turns in roasting and preparing the coffee all over again for better luck. If a woman delivers during the first round of the coffee ceremony she is considered lucky and blessed. (Interview, Amhara, Andenet)

A single coffee ceremony takes about an hour or two. One can imagine the amount of time spent pleading and praying to save women's lives. Various socio-cultural delays in the decision to take women to health facilities have been discussed elsewhere (Dudgeon & Inhorn, 2004; Gurmu & Dejene, 2012; Pacagnella et.al, 2012). However, in times of emergency such delays in deciding to take women to health facilities could partly be mitigated if the traditional practices were understood and considered in the health policies. More women might utilize health facilities if some of these practices were considered or included in the facility-based health delivery processes that women feel estranged from. The government has made efforts to improve and make facility-based delivery friendly and comfortable to women.

There has been a recent initiative in some health centers to mobilize the community to contribute grains to prepare *Genfo* for mothers delivering in the health facilities. These are positive initiatives that might encourage women to visit health centers in times of complication. However, there is also a need to improve home based-delivery since the majority of the women in the nation and in these regions in particular, prefer to deliver at home. In addition, many studies have discussed the benefits of antenatal care for early detection and decision to improve maternal health outcomes of pregnant women. Hence, bringing these services closer to the communities and making them cost free will allow women and their communities to decide whether to deliver at home or in a health facility ahead of time.

Assuming that the mother delivers the child safely, the postpartum phase is another aspect that requires a closer look in terms of maternal health. After delivery, the women in the house prepare food and drinks. *Tela* and *Areki* (local alcoholic drinks) are prepared to celebrate the birth. Both in Amhara and Oromia the woman who gave birth does not leave the house for 5 up to 10 days. Amhara participants explained that this is to ward off evil spirits since the mother is still bleeding and has not healed. In Amhara and in some cases in Oromia, on the seventh day after birth the woman and her new born child will be sprinkled with holy water.

> After delivery, a woman does not leave the house until the 10th day. She is treated until her body heals. Also, someone (youngsters usually female) must accompany her when she goes to the toilet. This is to protect her from evil spirits. She also does not go to the market until 6 months since we do not know what might happen. "Dehur nat" she is a new mom. (Interview, Amhara, Andenet)

In Oromia, the explanation for not leaving the house was not as religious as that given by the Amhara participants. Participants in Oromia noted that women do not leave the house to avoid illness. In addition, new mothers are bathed in herbal water a few days after birth. This is also part of the healing process. A woman in the FGD in Oromia explained women's postpartum experience.

> As an expression of relief and happiness the family members gathered there will cheer shouting: "Elelelelele!!" five times if it is a boy and four times if it is a girl. After the birth of the child, the mother is confined to the house for 5 days in order to avoid illness due to sudden exposure to the elements. On the first or any of the next days she takes a bath with hot water boiled with some fragrant herbs. Usually, on the fifth day, when she is out of confinement, family members, relatives and neighbors are invited to a feast to celebrate the birth of the new child. (FGD, Oromia, Mudena Ibayyuu)

When a woman gives birth to the preferred gender (son), it brings her praise and respect in the Amhara and Oromia community. The actual chant or ululation (*Eleleta)*

varies in numbers for a boy or a girl depicting the preference for a son. Amhara women and their families as soon as they find out the child's sex will do their ululation nine times for a girl and twelve times for a boy. An Amhara woman explained the reason as follows:

> It is believed that men/boys are born with full bodies and they tell us that females are not full bodied at birth. It is probably men who said that, why would women say that about themselves. (Interview, Amhara, Andenet)

Such examples depict the gendered preferences and discrimination women and girls experience from birth. The woman's statement above challenges the gender bias in this spiritual/religious ritual as brought about by men and not by the God. After delivery, the Orthodox Christian Amhara and Oromo women noted that the mother and the baby are placed in seclusion (*aras bét*) for 40 or 80 days depending on the sex of the child until the day of baptism. Specifically, in Amhara, on the baptism day, usually the 40th day for the boy and 80th day for the girl, the woman and the child will wear their religious necklace (usually a cross) together as a symbol of reaffirming the mother's faith. In the Amhara context the seclusion has religious meaning mainly to protect both the mother and child from evil spirits and the evil eye (*buda).* There are also experiences of cutting the young children's hair short usually for girls and cross dressing them in order to protect them from *buda* or the evil eye.

There are positive aspects to postpartum seclusion. The seclusion is the time where the new mother rests from all the laborious working conditions that rural women endure in their lives. The mother is provided with nutritious foods (meat, eggs, butter, porridge etc) prepared to help her heal. She will not leave the house or her bed in the presence of other people with the exception of her mother and family members in order

to protect her from the evil spirits. On the other hand most of the complications that may occur during this phase such as postpartum hemorrhage or complications that may occur with the child are often kept a secret since revealing such conditions are considered bad fortune for the mother and the child. Hence the delay in taking the women to health facilities also extends into the postpartum phase which may result in maternal and/or infant mortality. Studies on maternal mortality in Ethiopia also inform us how women are losing their lives during the postpartum period (Kaba et al., 2016; Sipsma et al., 2013; WHO, 2013).

Conclusion

Overall I argue that understanding and recognizing women's beliefs, rituals and cultural practices helps reveal the reasons why women prefer to delivery at home and their reasons for the delay in seeking health care after the onset of maternal health complications in these regions. In this chapter, I have described socio-cultural factors that women and their communities discussed that contribute to women's maternal health outcomes. Surprisingly there is no strategy or key indicator in the National Health Policy and Reproductive Health Strategy that specifically addresses these traditional practices and religious nuances. The general statement made as a target or strategy is the provision of education and information for women and the community (FMOH, 2006, 2015). A homogenized education and information system that does not take into account the socio-cultural specificities and economic conditions is not likely to be effective in meeting the maternal health demands and concerns of Amhara and Oromia women.

Another major government implementation strategy has been to eradicate socio-cultural practices such as early and polygynous marriages and the actual traditional birthing practice through legal enforcement. I argue that this strategy has not been effective in addressing socio-cultural issues. Customary marriages and traditional birth practices will continue to occur despite legal enforcements. The government's strategy is mostly based on the development and modernization assumption that women and their communities are backward, that their practices are dangerous, and that they need to be eliminated. As noted in chapter three participants discussed the challenges and legal measures women and TBAs encounter in Amhara as a result of home-based delivery. These measures, apart from alarming the pregnant women and the communities that support them, have the potential to gradually eliminate the social and cultural support women get from TBAs and their communities. The governments' assumptions and implementation strategies are faced with resistance from the community since the solutions have not included the communities themselves. The policies and implementations should include dialogue with the community about these socio-cultural beliefs and practices and a collective decision on how best to improve the maternal health of women.

Amhara and Oromo women need to be informed about the harmful effects of the modern family planning methods that are being administered in their areas. Moreover, the health complications and side effects that result from these hormonal drugs should be taken seriously. Contrary to what health professionals and government policies assume, women and their communities have made an informed and conscious decision about

when and how to give birth and how to limit their pregnancy based on their socio-cultural and economic conditions and the health services that are made available to them.

CHAPTER FIVE

THE ROLE OF MEN IN MATERNAL HEALTH

This chapter deals with the role of men in maternal health and the overall conclusions and possible community-based recommendations from what was observed and discussed with Andenet and Mudena Ibayyuu community members in Amhara and Oromia regions. Men influence the reproductive health outcomes of women both positively and negatively. Recent studies have confirmed the crucial role that men play in maternal health outcomes as they make decisions on the social, economic and cultural conditions of women and have a significant impact on whether or not women seek health care (Alva, 2012; Berhane et al., 2001; Carter, 2002; Dudgeon & Inhorn, 2004; Kakaire et al., 2011; Stephenson et al, 2012). Carter (2002) notes that especially in poor rural settings, "the involvement of husbands, among others, could be the difference between a healthy birth and a maternal death for purely instrumental reasons" (p.437). Dudgeon & Inhorn (2004) note that because men mediate women's access to economic resources in many parts of the world, women's nutritional status, especially during pregnancy, may depend heavily on male partners and relatives (Dudgeon & Inhorn, 2004). In addition, transportation to health facilities in poor infrastructure settings also tends to be mediated by men in times of emergency obstetric conditions (Berhane et al., 2001; CSA, 2005 & 2011).

Literatures that discuss the African context at large and Ethiopia in particular reveal that men have tremendous social and economic power in marriage, in the household, and in the community (Alva, 2012; Berhane et al., 2001; Kakaire et al., 2011). Kakaire et al. (2011) for instance assert that African men have great control over their

partners and that "they decide the timing and conditions of sexual relations, family size, and whether their spouse will utilize available health care services" (p.2). Specific studies conducted in different African countries including Uganda, Rwanda and Ethiopia suggest that there are similarities that we can draw on with regard to men's dominant role in relation to women in different cultural, geographical and socio-economic contexts (Alva, 2012; Berhane et al., 2001; Kakaire et al., 2011). However, we also need to study and examine the differences in the construction of masculinities and the role of men in specific local contexts to understand varied forms of gendered interactions that shape reproductive health outcomes of women in different nations.

Studies that recognize the crucial role that men play in reproductive health also duly criticize how numerous reproductive health programs have been targeting women as the sole responsibility-bearers in maternal health issues. Reproductive and maternal health programs have neglected the powerful role that men play in the family as decision makers on assets, income of the household, family size, sexual relations, partner's mobility and access to information on health care (Dudgeon & Inhorn, 2004; Gurmu & Dejene, 2012; Pacagnella et al, 2012; UNFPA, 2008). However, in the past few decades various programs and interventions have emerged globally with an approach to reproductive health challenges where women's interaction with their male counterparts is accounted for in achieving better reproductive health outcomes for both men and women. This is a new reproductive health paradigm that has emerged after the International Conference on Population and Development (ICPD) in 1994. My specific inquiry about men and maternal health is therefore part of the new reproductive health paradigm that seeks to understand men's social interactions with women and examines how social

constructions of gender, class, marriage and power dynamics in the household shape the role of men in maternal health.

In a country where the maternal mortality rate is among the highest in the world, it is important to understand how men take up the role of being husbands and fathers in their cultural contexts. Here, I discuss existing literatures on the construction of masculinities in Ethiopia and I analyze the primary data collected from the interviews and FGDs in Mudena Ibayyuu and Andenet Kebeles along with some of my findings from my previous studies in Ethiopia. [49] The discussions reveal the socio-cultural and historical construction of masculinities in Ethiopia specifically in the Amhara and Oromo context in relation to marriage and maternal health. The findings from the study reveal the presence of multiple forms of masculinities, particularly the existence of alternative forms of masculinities contrary to what is usually presented as patriarchal and dominant roles in different reproductive health research texts. I argue that these alternative forms of masculinities can serve as entry points in bringing about social and behavioral changes. They can also be employed to create community and government based initiatives for maternal health emergencies that are legitimized and supported by men and women in the community.

The New Global Reproductive Health Paradigm Post-ICPD

Before discussing social constructions of masculinity in Ethiopia, it is important to discuss how the study of men in reproductive health and particularly in maternal health

[49] I have used the frameworks and arguments from my previous studies on masculinities, mainly a baseline study I was engaged in regarding emergency access to health service in Amhara and SNNPR (Southern Nations, Nationalities and People's Regions) with the FMOH and the World Bank in 2010 and my study on obstetric fistula in 2008 that show similar results about men's dominant and non-dominant masculinities.

issues emerged and why this has lately gained global attention. Despite the crucial role that men play in household decision-making, more specifically in the African context, previous themes of global reproductive health programs focus only on women's experiences and the provision of family planning to address maternal health issues (Berhane et al., 2001; Dudgeon & Inhorn, 2004; Gurmu & Degene, 2012; Sandisky, 2011). Reproductive health frameworks that focus only on "female empowerment" and family planning have been duly criticized for their lack of comprehensive approaches to address reproductive health issues (Petchesky, 2003). Carter (2002) asserts that "lessons have already been drawn from the unintended, and often deleterious, consequences that past well-meaning health and development projects have had on women because of the faulty assumptions about gender underlying them" (p. 438).

The ICPD laid the foundation for a different approach in addressing sexual and reproductive health challenges of men and women. The plan of action formulated during the conference emphasized the need to understand the role of men in the sexual and reproductive health of the family. Barker (2004) notes that the plan of action was "a manifesto for a gender revolution", engaging men to achieve gender equality in their social relations (Barker et. al, 2004, p.148). The 1994 ICPD Program of Action explicitly calls for the inclusion of men in women's reproductive health through three avenues: (1) the promotion of men's use of contraceptives through increased education and distribution; (2) the involvement of men in roles supportive of women's sexual and reproductive decisions, especially contraception; and (3) the encouragement of men's responsible sexual and reproductive practices to prevent and control STIs (Barker, 2006;

Dudgeon & Inhorn, 2004). These avenues have been utilized by various groups as key methodological frameworks employed for research and interventions.

However, there have been challenges in involving men in reproductive health programs after the ICPD. In most cases, programs are framed in such a way that men become peripheral and an additional support system to women who are considered primary responsibility bearers for reproductive health issues while specific needs and roles of men are not addressed (Dudgeon & Inhorn, 2004). In addition, many reproductive health programs only focused on family planning and contraception and the role of men in other reproductive health issues such as maternal health were not addressed. Another major concern was that interventions were created in such a way that women's reproductive health issues are sidelined and resources are drawn to programs focused on men's reproductive needs (Barker, 2004).

Interventions designed to engage men lack the necessary information required to identify and understand men as active, responsible partners and to translate these needs into reproductive health programs and policies that benefit both men and women (Alva, 2012; Dudgeon & Inhorn, 2004; Leonard et. al, 2000; Sharma, 2003). To address such challenges, in recent years numerous studies have focused on men, exploring their roles and responsibilities in reproduction (Sharma, 2003). Even when such research is conducted the focus has primarily been on the role of men in family planning concerns and little attention has been provided to the role of men in maternal health issues (Alva, 2012). Studies specifically focusing on issues such as men's engagement and the role of men in pre and post-natal care, the influences of men's behavior and practices related to the conception, pregnancy, and childbirth outcome have been understudied and are

poorly understood (Alva, 2012; Dudgeon & Inhorn, 2004). Information on men's involvement in obstetric emergencies usually comes from accounts provided by women after the event has occurred and few interventions have targeted men in childbirth decision-making processes (Berhane et al., 2001; Dudgeon & Inhorn, 2004).

Efforts to balance and strengthen the link between studying men for the benefits of men and studying men for the benefits of women are crucial in moving forward with a comprehensive reproductive health paradigm. Barker (2006) in another article argues that time and resources should be allotted to work with women directly as well as to engage men and boys for gender equality. This approach resonates well with various African feminists' understanding and conceptions of gender relations and social justice for both women and men. In addition, the consequences of perpetuating patriarchy should also be seriously considered as we "help men to help women". In other words, reproductive health intervention outcomes that continue to provide men with more decision-making power over women's bodies should be avoided at all costs (Barua, 2004).

Looking at the Ethiopian context, the National Health Policy section 8.1 states the significance of paternal involvement in maternal health issues. However not a single strategy, target or indicator has been established to produce outcomes or measure results pertaining to the role and involvement of men. The Ethiopian FMOH does not have reproductive health programs that specifically target men as entry points to redress maternal health complications. This is also evident in the National Reproductive Health Strategy document and the most recent Health Sector Development Program (HSDP IV) midterm review (FMOH, 2006, 2016). This is intriguing given the fact that Ethiopia is among the participants and signatories of the ICPD 1994 plan of action; and the fact that

government initiatives are extremely crucial in the successful implementation of reproductive health programs nationally.

Recent small scale programs of male involvement have been initiated by non-governmental (predominantly) international organizations. *Men as Partners* programs of Engender Health, Hiwot Ethiopia, Pathfinder International, and *Addis Birhan* of the Population Council are among the few reproductive health programs that work with men in selected Woredas and regions of Ethiopia. Compared to Ethiopia's population and what the government health programs cover, these organizations can only reach a limited section of the population. In addition, most of these programs are not specifically targeted at maternal health concerns.

The absence of research on men's role in reproductive health and particularly on maternal health issues at the national level also points towards the lack of attention given to this matter. There have been studies that focus on men's attitudes and perceptions on family planning but not specifically focusing on maternal health issues. Research on maternal health issues in Ethiopia similar to findings elsewhere usually asked women about the experiences of their husbands (Dudgeon & Inhorn's, 2004). Such studies would have been more useful if they were analyzed in conjunction with the view of men. This is precisely why this study and other similar studies would be significant contributions to the study of men in maternal health in Ethiopia. The findings and discussions from Amhara and Oromia incorporate the views of men about maternal health issues and seek to analyze their responses in light of the social constructions of masculinity and how that impacts women's health. Unlike other reproductive health programs, biomedical and social science studies that only interview women about maternal health issues, this study

simultaneously engages community members, specifically men who play significant roles in the health of women.

Dominant/Hegemonic Conceptions of Amhara and Oromo Masculinities

Hegemonic masculinity refers to the dominant traits, behaviors, practice and conceptions of manhood that legitimize and perpetuate the superiority of certain groups of men over women and other men (Connell, 2005). From a global perspective, rural Ethiopian men in the study are among the marginalized masculinities in terms of race, class and location. However, these men still exercise a significant amount of socio-cultural and economic power over women in their own communities. Hence, part of the effort in this study is examining these dominant conceptions of masculinities in both regions and exploring western and local development and reproductive health narratives about Ethiopian masculinities. The idea of recognizing and exploring multiple masculinities as outlined by Connell & Messerschmidt (2005) is particularly significant for this study. Methodologies in other masculinity studies elsewhere that recognize alternative, non-dominant masculinities in research challenge dominant, hegemonic masculinities and explore possible sites of gender complementarity and change in the community (Diaz, 2011). Hence, my inquiry regarding Amhara and Oromo men is precisely to explore multiple forms of masculinities.

As mentioned above, research about masculinity in relation to marriage, maternal health and more broadly to reproductive health seem rather limited in Ethiopia. Specifically, studies on Ethiopian masculinities so far have mainly focused on violence, war, warriorhood, ethnic identity and other factors that are not directly related to health (Hamer & Hamer, 1966; Hussein, 2005; Levine 1966; Sumner, 1995). This section

discusses existing studies on dominant forms of masculinities and reproductive health literatures in relation to the research findings about Amhara and Oromo masculinities. It is a process of both challenging and affirming what has been documented as forms of hegemonic masculinity.

Donald Levine and Reminick (1973) are among the prominent western scholars who have extensively written about Amhara culture and masculinity. Similarly, Hussein, 2005; Legesse (1973); Sumner, 1995 and Levine (2000) among others have provided us with detailed accounts of Oromo masculinities in the different parts of Oromia. Such international and local scholars have mostly discussed and affirmed certain tropes of masculinities, gender relations describing the monolithic and hegemonic conceptions of masculinity that continue to shape our understanding of men in Ethiopia (Berhane et al. 2001 & Gurmu & Dejene 2012). These hegemonic ideals also impact policy formulation and implementation on reproductive health issues.

Looking at the Amhara masculinity, Levine (1966) provides historical contexts of war and bravery that have contributed to the construction of masculinities in Amhara and the meaning of *"Wondenet"*- the Amharic term for masculinity. He asserts that Amhara masculinity is tied to physical stamina, mental bravery and courage. He also provides quotes of men boasting *"fukera" "Shilella"* about killing enemies, or beasts. Men being able to kill, men not crying, men drinking alcohol and eating spicy/hot foods, men walking long distance for many days without eating and withstanding hardship without complaint were all ideals of masculinity Amhara men discussed in Levine's work.

Levine (1966) (2005) appropriately notes that the Amhara ethnic identity has been historically, politically and culturally dominant in shaping national ideals of masculinity,

through historic war conquests, bravery against colonialism and foreign enemies. Levine notes that young Amhara boys are trained from birth on how to be "*Gobez*" (brave), how to defend themselves and attack their enemies and how to be strong all tied to being a man. I concur that historical legacies of bravery, warriorhood and courage continue to shape dominant forms of masculinity in Amhara today. A famous Amharic poem explaining the bravery and courage of an Amhara King, Emperor Tewodros who chose to kill himself on the hills of Mekdella rather than to surrender to the British forces in 1868 best explains these ideals:

> *Mekdela Afafu Lay Chuhet Berekete Ye setun Alawekim Wond and Sew Mote*: I hear the mourning from the hills of Mekdella, I'm not sure about the women [the other men] but I know that 'the' man has died (meaning: only one man was man enough not to surrender and die).

From the above poem, we can infer that the men who are not brave were referred to as women. Bravery is not something that is often attached to ideas of femininity. Corresponding with Levine's accounts, men in Andenet in Amhara discussed ideas of bravery and warriorhood as part of their masculinity. Men in the FGD explained that a brave man is one who will fight and defend himself when provoked and one who lets go knowing that he can defeat his opponent in a physical fight. Interview participants also noted that specific to their locality, manhood or masculinity was also connected to being an outlaw or a bandit that forcefully takes people's properties. This form of masculinity as they have explained is unique to some areas in the Amhara region where the topography of the Woredas are convenient for bandits to easily hide and rob people going to the market and to the main towns, in this case to Merhawi or Amarit. Participants

explained that these types of men used to be sought after for marriage and kinship since no one dares to touch their property. A respondent explained as follows:

> In the old days, we would say that so and so is a brave and strong man if he dares to trespass into his neighbors' land without their consent and if he steals or takes away someone's land or herds *(Ekele Ye sew dej Yidefral)* but nowadays things have changed we no longer respect such men. (Interview, Andenet, Amhara)

The above quote shows a shift in the constructions of masculinity. Many respondents both men and women explained that although the notions of bravery, strength and warriorhood are still prevalent as prominent tropes of dominant masculinities in Amhara, masculinity traits tied to robbery and being an outlaw are no longer valued. Participants discussed what Amhara men and women now value and respect as an ideal form of masculinity. Both interview and FGD participants discussed masculinity in relation to hard work and good farming practices and the "proper" management of one's household. In addition, contrary to Levine's account of Amhara men drinking alcohol as a dominant character of the ideal man, participants in Andenet noted that such forms of masculinities are frowned upon now. A participant explains as follows:

> A good man is good farmer who is hardworking and who does not spend or waste his money in town. We call this type of man *Gobez* [clever, brave]. A man that spends the day and night wasting his earned money on Tej and Araki (local alcohol drinks) and who comes home drunk or loses his money is called foolish. (Interview, Andenet, Amhara)

Participants discussed ideal manhood in terms of how well he works on the farm and how he manages to save and accumulate wealth. "If the man supports his family, saves what he earns, manages to save and buy more oxen and improve his income, has

good and respectable relations with people of the community, this man is considered a real man" (FGD, Andenet, Amhara). There are also proverbs and saying that Amhara participants shared in relation to this. "The harvest of the hard-working farmer was so much that the sound of the mill was roaring until the end of the rainy season."

The term *Dhiira* denotes a man in the Oromo community in Mudena Ibayyuu. We also find similar dominant ideals of masculinity among Oromo men. The Oromo saying "a brave man is a spice of life" denotes how bravery is an important part of Oromo men's ideal and dominant masculinity (Hussein, 2005). According to the participants in the interview bravery, warriorhood and good farming practices denote the ideal form of masculinity among the Oromo in Mudena Ibayyuu. A man is held in high regard if he is hard working and earns good harvest, or is good at raising cattle and animal husbandry. A man is also considered a good man if he is self-sufficient and not a drunkard and extravagant.

A significant aspect of dominant conceptions of masculinity in both regions is the ownership of property, assets and wealth accumulation. This has also been confirmed by other masculinity studies in these regions (Legesse, 1973; Levine, 2000; Reminick, 1973). In Amhara, particularly in the old feudal system, *Rist* meaning land inheritance is tied to kinship and patrilineal bloodline through which men own property. Hence, land is a man's livelihood. It is tied to a man's masculinity and identity in Amhara. Class, age and kinship (paternal kinship) play a crucial role in positioning men as *arso ader* (meaning peasant) and *Balabat* (literally meaning someone who has a father but denotes ownership of property and being a landlord). It is also interesting that both terms are exclusive to men even though in the Amhara context women can inherit from their

biological parents and are engaged in most of the farming activities (Reminick, 1975). Hence, in the Amhara context ownership of property is tied to manhood. Similarly, in Oromo culture a man who has land and cattle is considered to be able to take care of his family. Participants in Mudena Ibayyuu noted that an Oromo man is considered wealthy if he has lots of cattle and large plots of land. Losing the property will mean that the man has lost his social status in society. Participants from both regions noted how the shift in the construction of masculinity from bravery and warriorhood has incorporated notions of wealth acquisitions. Therefore, dominant ideals of masculinity in both Amhara and Oromo cultures are related to property ownership and income.

Scholars have noted that apart from bravery, warriorhood, wealth and other forms of markers, the social constructions of masculinity are strictly tied to gender relations where males are accorded higher status over females (Hussein, 2005; Levine,1966). In addition, age plays a tremendous role in shaping masculinity even in the absence of the above mentioned attributes. An elderly man will be able to attain the highest prestige. The participants from both regions and particularly from Oromia noted the influential power elders especially male elders have in the community and in the context of marriage. In the traditional political and administrative system-*Gada* of the Oromos, age and descent have a major role in deciding men's position and rank. Elder men assume the highest ranks and are held in high regard in the Oromo *Gada* system. They also play the role of mediators, in times of conflict between households, tribes etc (Hussein, 2005; Legesse, 1973).

In both Amhara and Oromia, dominant manhood is defined in relation to womanhood. Whatever a man is not supposed to be is termed as womanish and feminine

often as a derogatory remark. With the exception of Hussein (2005), other studies of masculinities in Ethiopia have not addressed the fact that a man who does not perform any of the dominant ideals is regarded as feminine. In Amhara, men who do not abide by dominant ideals of masculinity are often referred to as "*Set"* or *"Seta set"*: meaning a woman, usually in the form of insult or derision. A woman in Oromia also explained that "If a man does household chores, fetches water for the wife, baby sits, cooks food, or opens the food basket and prepares the table, he is despised and looked down upon as womanish" (FGD, Mudena Ibayyuu, Oromia). Another proverb that ridicules men who do not perform hegemonic masculinities in the Oromo culture is the proverb "A husband who fears his wife cannot father a child" (Hussein, 2004). This proverb is basically to emasculate the man who respects the views of his wife or abides by what his wife says.

It is also important to note here that women have a major role in perpetuating patriarchal dominant masculinities and femininities in these areas. Similar to the Oromo woman above, some women in both regions termed men as womanish when describing non-dominant form of masculinities. Another aspect worth discussing is that in both regions masculinity is not always attached to the sexuality of men but rather to the achievements of other traits considered masculine such as bravery, courage, stamina and so on (Levine, 1966). In this regard the term "*Wond*" can also denote females who perform these identities in Amhara. Masculinity can be expressed in two different ways in relation to women when expressed as *"Wonde nat!"* in appreciation literally meaning she is a man!, and "*wonda wond!"* when expressed as an insult to women who perform any form of female masculinities that are not accepted by the society. Likewise, in Oromia a participant explained that "If the woman is hard working and manages her

home properly, people might say so and so … although she is dressed like a woman, she has the quality of a real man". Therefore, masculinity is often attached to positive characteristic while femininity is often used to describe shortcomings.

The findings of this study and literatures on dominant Ethiopian masculinity both confirm that in the Amhara and Oromo cultures men are raised to view women as inferior beings that need to be controlled (Hussein, 2005; Levine, 1966; Reminick, 1973). Dominant ideals of masculinity in both Amhara and Oromo cultures expect men to discipline women and often limit their mobility. In an Oromo marriage, a woman is considered inferior to her husband and is often regarded as under his control. A married woman's identity in the Oromo culture is defined in terms of her husband's identity and a woman is not considered as a person independent of her husband. Sumner (1995) similarly notes that an Oromo woman is described and understood through her husband's identity. Through proverbs and poems, a man is socialized on how to "handle" his household-his wife and children. Hussein (2005) notes the proverb "The lady whose husband spoils her, slips from the tanned hide" is used to warn him to be stern in his management of his wife (p.63). A similar proverb: "One who has spoiled his wife eats roasted barley for his supper as one who has spoiled his horse carries the saddle at night" (Hussein, 2005, p.86).

Often subduing women comes with violence. A woman in Oromia explained the cultural encouragement of men to control and subdue women with violence as follows:

> Another frightening experience is the cultural practice in which the husband is encouraged to show his physical dominance and ensure the wife's submission by frequently beating/whipping her for no reason at all. The society praises such a husband stating that: "He is a serious husband who has proper control over his wife" (Interview, Mudena Ibayyuu, Oromia)

Overall the findings from this study affirm that hegemonic constructions of masculinity attached to bravery, war and warriorhood have slowly shifted through time to definitions of masculinities on the basis of livelihood, hard work, accumulation of wealth and property ownership and subtle and peaceful behavior towards one's neighbors and community members. This corresponds with Connell's & Messerschmidt's (2005) assertions about the concept of masculinity/ masculinities as dynamic and changing through time and socio-cultural contexts. Dominant notions of masculinities related to superiority especially to women and other men - bravery, courage, age, class (property ownership) and economic independence - influence the construction of masculinity in Amhara and Oromo cultures. These discursive ideals of masculinity have material consequences for women since they influence how a man performs his masculinity in the context of marriage and in times of maternal health complications. Reproductive health research by Berhane et al. (2001) and Gurmu & Dejene (2012) have come to similar conclusions about Ethiopian men's social interaction with women and the role of men in household decision-making, specifically men's power to limit women's visits to health facilities. These are significant observations made by other studies about hegemonic masculinities and their impacts on the lives and health of women.

However, as we will see further, discursive ideals of hegemonic masculinity may vary from the experiences and realities of actual men (Elias & Beasly, 2009). Not all Amhara and Oromo men adhere to the hegemonic and aggressive ideals of warriorhood and bravery and not all Amhara men "kill" or "drink" as Levine (1966, 2005) and others have noted. Some women and men expressed what a good man should be in Amhara and

Oromia expressing ideas of gender complementarity. A man in the FGD in Amhara explained that "a good man consults with his wife on how to make his home better, what to sell in the market and how to build a new and better home." However, studies on Ethiopian masculinities do not present other forms of masculinities that do not adhere to these dominant conceptions of masculinity for various reasons. In fact, my discussions with men about maternal health issues in this study and my previous research on the role of men in maternal health revealed forms of masculinities that are different from the dominant ideas presented in other masculinity studies. I present the experiences of men who are supportive of women during pregnancy, men who cried for their wives during maternal health complications, men who were concerned about their lack of property and assets in times of maternal health complications and men who explained in detail about the arduous walk on foot to health facilities and men who are worried about the loss of assistance from traditional birth attendants for their wives during emergency travel to health facilities as a result of the health policy. A complicated mix of dominant and alternative masculinities create the realities of men in these settings.

Masculinities and Maternal Health

As mentioned above dominant ideals of masculinity influence the day to day interactions of men and women in these regions. Examining the relationships of men with women in the context of marriage is useful in revealing how men perceive their role in maternal health. Literatures on marriage, specifically early marriage, are mainly written about women and young girls (Gurmu & Dejene, 2012; NCTPE, 2008). The dynamics in which men become husbands and fathers are not well understood and even the age at marriage for men is rarely discussed in both masculinity and reproductive health studies

in Ethiopia. Examining how men have come to take up these dominant roles in marriage is significant to address underlying social causes of maternal health issues. The discussion with men and women in the interviews and FGDs in both regions revealed that men too are married at a very young age (usually older than girls but still young), without their consent based on their parents' decisions. The promissory marriage and early marriages discussed in chapter four in Amhara and Oromia regions also pertain to young men who are married off at a very young age often without their consent. A participant in Oromia explained as follows:

> I was married when I was 16, I did not know the girl until the wedding day. I had no intention of marrying. It was a family arrangement. When my father died, my grandfather thought I would go away to the city. So, he quickly arranged for me to marry. Then in 1989 EC (1996), we had a child. Then I had to take care of my wife and the child. My wife was very young and timid she always wept. It took time for us to develop a relaxed relationship. During the betrothal, my family had to pay Birr 320 in the form of dowry and buy her [his wife] clothes as I was a young boy. My family took care of these expenses. (Interview, Mudena Ibayuu, Oromia)

The pressure to become a man, to provide for his family, to own property or assets, to be able to plough and cultivate/farm, perform well sexually, control or dominate his household including his spouse and children are realties young boys endure at a very young age. The discussions in these regions also affirm that masculinity is highly attached to the heterosexual meaning of being a man and being able to accomplish sexual duties for Amhara and Oromo men. Hussein (2005) also notes that in the Oromo context the ability of the man to impregnate a woman and his ability to bear children earns him respect in the community. In marriage, similar to women, at the night of the wedding, men (particularly young men) face tremendous pressure from society on their ability to "deflower" the bride. A man's ability to control and dominate his wife in sexual relations

is a distinct trait of a dominant masculinity in both regions. A woman in Amhara explains her first sexual experience with her husband and how he defied this dominant conception by waiting as follows:

> I cried and I was terrified of what was going to happen when I met him (her husband). My family forced me and told me that I have to get used to it and that I am now married. Luckily the man [her husband] waited for me to calm down and to feel at ease before we slept together. (Interview, Andenet, Amhara)

There seems to be lack of research on society's regulations and punishment of young men who "fall short" of these hegemonic ideals. If a man respects his wife, or if he listens to a woman's opinion or fails to keep his wife "in check", if a man is unable to perform his sexual duties, if a man is not able to work, or own property to support his family or if he refuses to marry, there are consequences of being emasculated and becoming less of a man. Hence, ways to hold communities accountable for the pressure they put on men as well as women and bringing about social and cultural change is imperative in this situation.

As noted above, some of the pressure comes from women in the community. Mainly, the man's female relatives put pressure on the man to decide on pregnancy and childbirth and his wife's health. As discussed in chapter four community members and elders pressure the couple to have children immediately after marriage. Women are the ones that teach young men what it is to be a man. In my previous study about Obstetric Fistula, the majority of the husbands that had left their wives who suffered from obstetric fistula were pressured by women in their families (Teshome, 2008). Hence in this regard women also perpetuate hegemonic masculinities that impact the health and wellbeing of women.

The Role of Men During Childbirth

Even though the delivery process is traditionally a woman's domain both in the Amhara and Oromo culture, men play a tremendous role during labor and delivery. Prayer and traditional rituals are some of the things men in the family will engage in when labor is prolonged. Men will pray outside while women pray inside the house. While praying, both men and women will loosen their belts and *Mekenet (*cloth tied around women's waist) as a symbol of the woman's womb loosening, enabling her to give birth in peace. Interestingly in the case of Amhara, FGD participants noted that the men are blamed for the obstructed labor and the misfortune of the wife. This is an interesting dynamic since previous studies show that women were the only ones blamed for the misfortune of prolonged labor as it is considered a wrath from Mary towards women (Girma, 2008, Abcon, 2011). A man in the FDGs explained that "They [men] unbuckle their belts when labor is hard for the woman, and ask for the help and mercy of the Holy Mother. And we say that the husband is bad or mean spirited in his heart when the labor is intense" (FGD, Andenet, Amhara).

Obstructed labor and the suffering of women during delivery is a difficult and unfortunate circumstance for men in the family. It is a time when they also deal with great emotional, social and economic hardship and are faced with making difficult decisions. In both regions participants noted that the man of the house is the one to ultimately decide if and when the woman will go to the health facility. Elder women in the family will often advise the man taking into consideration the family's economic means and the distance to health facilities. A man in Oromia described his experience as follows:

> When she [his wife] was in labor, the ladies told me to go away since they know how I worry. I stayed at the farm, but could not concentrate, could not eat lunch. When it was time to release the oxen, I rushed home and I took her to the HC; we stayed overnight there and then brought her home. In the morning, she gave birth. (Interview, Mudena Ibbayyuu, Oromia)

Men are often in charge of organizing transportation in times of maternal health emergencies. Men and women in both regions cited the problems of roads and infrastructure when accessing health facilities specifically in times of emergency. Participants in both regions emphasized shortage of the ambulance services that the health center is providing. With only two ambulances available for each Woreda, men often have to prepare their own means of transportation to get women to the nearest health centers. Particularly in places where there are no roads and the ambulances cannot reach the community, the husband and other male community members have to carry pregnant women on *Karezas*-manually carried stretchers and walk on average four to six hours to the nearest health center or one and a half hours to four hours to get to where the ambulance will pick them up. In Amhara and Oromia, travelling long distances over mountains and across rivers is commonplace, particularly in the study area. A participant from the FGD in Oromia discussed transportation and infrastructure problems as follows:

> There are problems of transportation which we need to raise at the health center meetings and they need to be addressed. The woman who died last year in our area died because of transportation problem. In some Gotes there are rivers to cross and they pose big problems carrying the woman and the Karezas are also uncomfortable. The Gotes that are inaccessible include: Harbu Ibayyuu and Waayu (FGD, Oromia, Mudena Ibayyuu)

Even though the ability to travel long distances without complaint or to withstand hardship were mentioned in Levine's (1966) account of dominant masculine ideals among the Amhara, men in the interviews and FGDs of both regions were not hesitant to

discuss the agony and hardship of traveling to health facilities while carrying pregnant women without food and water in rugged terrain and across rivers. They explained the dangers of river crossing during the rainy season while carrying pregnant women. These are the circumstances where discursive hegemonic masculinities may not directly translate to the realities of men who carry out the physical labor of transporting pregnant women to health facilities. Men perform these duties because it is expected of them, however they do so not without fear of threat to their lives.

In the case where men do not have close male relatives nearby, these services are costly for husbands who may have to pay other men who will help them transport their wives to the health facility. The man provides food and covers accommodation for their help in addition to other transportation and medical costs he might incur in taking care of his wife (Sipsma, et al. 2013). Hence men often decide to wait and carry out religious and traditional rituals before seeking health services for their wives. While delivery cost is free in health facilities, treatment for other complications and maternal health services are not. Therefore, as explained by participants from this study and the previous study I conducted, a man may delay his decision to seek health care for his wife so as not to pay for additional hospital and transportation costs. In the context of poverty, where men might lose their entire property and assets due to healthcare costs, they are compelled to think twice about the decisions they make and literally pray to God that their wives will give birth safely at home. FGD participants in Amhara noted that some men might even wait a couple of days until they obtain a loan from neighbors so as not to sell cattle and property. Consequently, property ownership being tied to masculinity and its potential loss does have a major impact on why men delay or resort to other solutions before taking

their wives to health facilities. The fact that men have control over properties and that women have neither access nor control over such resources become detrimental to their lives as decisions are made by men in these circumstances.

On the other hand, in a context where men are providers for the household, the fact that men in both regions are not able to provide for their wives and protect them in times of emergency due to poverty can also be a process of emasculation. Men in the FGD in Amhara and Oromia noted how they would not let their wives suffer if they could prevent the complication or find the remedy for it. The men explained husbands' dismay to see their wives in pain after a taxing trip on these roads and to not be able to help them due to lack of money. It was clear from the discussions that it is very important for a husband or a father to be able to take care of his family in times of emergencies. This in turn means that dominant constructions of masculinity and their narratives in both reproductive health and masculinity studies exclude men who do not own property or who are willing but are not able to take their wives to health facilities during maternal health emergencies due to lack of resources and property. Understanding such dynamics helps health policies to devise ways to engage men earlier to help their wives through ante-natal care and support for pregnant women to avoid complications.

Health facilities are one of the places where men are involved during maternal health complications. In most cases after they have reached the health posts or health centers they are often referred to a hospital due to lack of equipment and skilled health professionals. Participants talked about referrals to Bahir Dar Hospital in Amhara region or to Woliso Hospital in Oromia. Interview and FGD participants mentioned the poor quality of services as one of the reasons why they are reluctant to take their wives to

health facilities. A hostile and insensitive treatment by health care professionals makes the health care experience difficult for women and men. After an arduous trip to the health facility, husbands who come with their wives or relatives are insulted for not queueing in line, for not coming on time or for not following what is considered "proper etiquette" by health care professionals. Participants in the FGDs of both regions discussed mistreatment and delay in the health facilities. Insults or mistreatments directed at their wives or themselves signifies their own emasculation in public. Above all, Amhara and Oromo men tie respect or being held in high regard in public to their notions of masculinity; hence, mistreatment in these settings is a possible reason why men would decide not to take their wives to health facilities. Improving health services and training health care professionals to respect the dignity of patients and families are possible policy considerations.

> The reception is poor and some staff members are reluctant and mistreat people. For example, I had taken my niece to the health center for treatment. But because of the delay and neglect, I had to bring her home and she had to deliver at home (FGD, Mudena Ibayyuu, Oromia).

Poor quality of health services deters women and their families from seeking health services. Sipsma et al. (2013) explains that "several aspects of delivery services offered at the health centers and health posts that were unappealing for mothers, including lack of sensitivity to patients' modesty, uncomfortable delivery beds/couches and potential separation from family members during labor" were reasons for women not wanting to deliver in health facilities (p. 1020). I argue that such mistreatment is part of the modernization narratives of health care professionals treating rural women and men as backward subjects in need of guidance and control.

As discussed in chapter four the postpartum phase is the time of rest for women. Generally, men are expected to respect this phase and they are supposed to comfort and please their wives. Usually the man slaughters a sheep or a goat in the woman's and child's honor. This is done so that the woman eats nutritious foods to recover properly. This is a time where women in most cases are safe from violence and mistreatment from their husbands. Husbands usually avoid annoying the mother (Hussein, 2004). In addition, the postpartum phase is a time where women rest from house chores, sexual contact and they also breast-feed longer to prevent pregnancy. These decisions are often respected by men. Participants and previous literatures affirm that, particularly among the Oromo, men will face serious resistance from neighborhood elder women for mistreating their wives after delivery. Such forms of community alliance among women against violence and the cultural delay of childbearing during the postpartum phase should be encouraged and replicated through health and development interventions.

Alternative Masculinities in Maternal Health

Previous literatures on reproductive health have made it seem as though all Ethiopian men adhere to hegemonic constructions of masculinity and that they easily take up their dominant roles in society and in marriage (Hussein, 2005; Levine, 1996; Reminick, 1973). However, the research findings suggest that there are multiple masculinities that exist beyond the scope of hegemonic ideals of masculinity in both the Amhara and Oromo cultures. As noted earlier recognizing alternative or non-dominant forms of masculinities in research is imperative to challenge dominant conceptions of masculinity (Diaz, 2011). Alternative forms of masculinities may also direct us to possible solutions in bringing about behavioral change in the community. Despite the

widespread discussions of men deciding negatively on behalf of women or men controlling women there is also a need to acknowledge that there are men who defy society's normative ideals of masculinity (Berhane et al., 2001; Gurmu & Dejene, 2012). The number of men who were willing to support women in their community simply by attending health center meetings, research and community consultation forums and focus group discussions and interviews such as the ones held in this study and the previous studies I took part in is proof that men are in fact willing to change the current maternal health situation for women. There are men and women in Amhara and in Oromia who defined manhood in terms of gender complementarity and respect towards women.

> A man who treats his wife well and who decides together with his wife is wise and he is considered a good man and a man who beats and belittles his wife and does not agree with his neighbors is called "foolish". Also, a man who is not hardworking is not considered a good man. (FGD, Andenet, Amhara)

There were also interesting discussions in the FGDs about men who were supportive of women's choices of when and where to give birth including supporting early health facility visitations for pregnant women. As discussed earlier, in the context of marriage there were men who did not want to pressure women into sexual intercourse or early childbearing. I have also encountered men in Oromia and Amhara who perform the daily chores that women do during the postpartum phase. A participant in Oromia for instance explained how he cleans the house, fetches firewood and water, grinds the mill and supports his wife after delivery. Similarly, an Amhara husband noted that he takes care of the young children and his wife's household chores when she is resting postpartum. These discussions show that there are many men in Oromia and Amhara who

would possibly do all they could to save the lives of women during maternal health complications.

Beyond the abstract figures of maternal mortality rate per 100,000 live births, the study of maternal health needs to explore what these complications and deaths mean to women's families particularly husbands, partners and children and to the society in general. Bridges (2011) notes that "Maternal mortality means that a child will grow up never knowing the mother and that the fathers, husbands, partners [families] will be grieving while simultaneously welcoming a child into the world" (p.110). The emotional aspect of men's engagement in maternal health is another dimension worth discussing. Men who took part in this study particularly in the FGDs in Amhara and Oromia regions were not hesitant to express their emotions of worry and grief when they talked about the challenges of taking their wives to health facilities or the maternal health complications and deaths that occurred in their areas.

Similarly, in my previous study on emergency access to health services in Amhara and SNNPR men in the community consultation forums were crying during the discussion forums, in public, when they talked about their wives, sisters, relatives or neighbors they have lost to childbirth or who have faced maternal health complications. Provided the cultural context discussed in this work where men do not express their emotions and cry, men's emotions (crying or feeling pain) show how maternal health gravely affects them as well and that there are non-dominant constructions of masculinity. Employing these emotions that men expressed to address underlying social issues such as early marriage, early child bearing, and decisions to seek health care for women could indeed be part of the intervention to engage men in maternal health.

The findings also resonate with my previous research with women who suffered from obstetric fistula due to birth complications in 2008, where husbands supported their wives despite societal pressure to divorce and abandon them. In this study, women explained that their husbands had stayed with them and that they were not appalled by the smell of urine and feces and did not blame their wives for their misfortune. I remember a woman crying for her husband and the challenges he overcame to bring her to the Addis Ababa Fistula Hospital. She explained that even after the occurrence of the fistula her husband would carry her on his back when they were crossing rivers, despite the fact that she was leaking urine and feces. She remembered how he used to massage her back after his long day of farming and how he helped his daughter with the household chores until his wife got better. These are men who can be models for reproductive health interventions. These are men that the government could possibly engage to challenge dominant conception of masculinity that negatively impact women's health.

Another discussion that defied dominant conceptions of masculinity in maternal health was the fact that there were men who understood their role and contribution to the patriarchal setting that women lived in and the gender division of labor that overburdens women. A man discussed how his wife is overworked as follows:

> She gets up early to prepare our breakfast and coffee. Before noon, she will bring my lunch and she will help me in the field. Shortly after, she goes back to prepare for supper. On Sundays, I usually rest but she is busy all the time. In the evening, she prepares supper and coffee, she stays up to nine and ten at night and goes to sleep after us. (Interview, Mudena Ibayyuu, Oromia)

Given the nature of subsistence life in the rural setting where both men and women work hard, the man's recognition of the double burden that women bear shows

that he is aware of the challenges women face in these contexts. Men from both regions also discussed their interest to organize emergency assistance services in their community. They also discussed the possibility of using pre-established community support systems such as *Edir, Equb* and *Mahibers*[50] or other money saving schemes to assist pregnant women financially in times of maternal health complications. So far participants and their communities have demonstrated their commitment to improving maternal health by raising funds for ambulance and by providing grain for women who deliver in the health facilities. In some areas FGD participants in Amhara noted that intermediate means of transportation such as horse/donkey carriages have been prepared for maternal health emergencies.

The findings overall demonstrate that dominant conceptions of manhood as outlined by various reproductive health and masculinity studies in the Ethiopian context do not always fit the realities of Ethiopian men. In addition, these men allow us to imagine more equitable solutions where men care and take responsibility for the challenges women face during maternal health complications. Despite their vital role in childbirth, men are often not considered in reproductive health interventions and women are assumed to be the sole responsibility bearers of reproductive health issues (Alva, 2012). The constructions of gender in international and reproductive health programs do not take into consideration the local understanding of gender and the ways in which these

[50] Edir: an association where communities help a mourning family socially and financially. Edir members also help the grieving family with work/chores and provide them with food supplies for their consumption and for their guests.
Equb: traditional saving and banking system conducted in groups where each member contributes on a monthly, weekly or bi-weekly basis. Each member takes turns in drawing the entire collected money.
Mahiber: is a community gathering held usually once a month. It is usually to celebrate some religious rituals. Social assistance and relations are strong in these settings.

social relationships influence the health outcomes of women. As previously mentioned women are often the target of education programs and awareness raising campaigns. Government health extension workers (HEWs) are also trained to educate women. We have seen that Amhara and Oromo men play a crucial role in childbirth yet they are not included in maternal health programs. Their role needs to be understood and addressed if women's maternal and reproductive health needs are to be met.

CHAPTER SIX

CONCLUSIONS AND WAY FORWARD

In this final section, I discuss my final remarks regarding the major themes discussed in each chapter and potential recommendations that I argue might contribute to the improvement of maternal health policy and implementation gaps. Over the centuries development and modernization narratives have influenced how the Ethiopian health system is organized. The historical tracing in chapter two brings out an important connection between the previous and current Ethiopian health systems and the discourse of development that has resulted in the prioritization of western medicalizations and knowledge claims over indigenous, traditional health knowledge. While 19th-century health interventions in Ethiopia strove to preserve indigenous traditional knowledge systems along with modern biomedical programs, recent policies have only left such efforts as lip service and have continued to favor biomedical solutions to replace and eradicate traditional community-based health practices.

The discussion about maternal health policies and implementation in chapter three confirms the prioritization of biomedical solutions. The nation's innovative community-based health implementation strategies are marked with underlying development and modernization narratives and assumptions that undermine the knowledge and reproductive desires and needs of women. Community-based maternal health initiatives such as HEWs and HDAs, despite their comprehensive and gender-sensitive outlook, have a modernization and development aspect that constructs local women and their communities as "passive," "ignorant" recipients of maternal health knowledge and

services. In addition, socio-cultural factors such as age, political biases and lack of experience of HEWs, deter the effort underway.

A major aspect of the government's implementation strategy that needs to be addressed is the lack of attention paid to local and indigenous knowledge systems. As mentioned earlier the health extension program is designed for the dissemination of health knowledge and information from the top to the bottom (FMOH, 2013). Hence, knowledge within the community, mostly the reproductive knowledge of women and TBAs, is often not considered or valued in the intervention process. TBAs are discouraged from assisting women in a context where the majority of women in Ethiopia still deliver at home (CSA, 2012; Shiferaw et al., 2013). "Globally, TBAs assist in 60–80% of all deliveries and even more in the rural areas of developing countries. For many women living in the global south, antenatal care, as well as institutional deliveries with skilled health workers, remains a distant reality" (Choguya, 2013, p.1). Hence, home birth is a priority for most women until the capacity of the health system to adequately finance maternal health services is enhanced and rural women can easily and willingly access health care services. Therefore, solutions that would make home-based delivery safer would work well with the current circumstances of rural Ethiopian women.

Having an open dialogue about what is useful and harmful about traditional birth attendance will help preserve safe and important community health practices and also address harmful ones. Integrating the work that HEWs and TBAs do in maternal health and particularly in delivery will be a mutually reinforcing and confidence building strategy in the provision of maternal health services. HEWs will gain acceptance in the community and they will also build their experience and confidence by working with

TBAs who have tremendous experience and knowledge in child delivery. Likewise, TBAs will also learn useful medical methods of early detection of complications and safe and clean delivery in the house with simple but significant medical toolkits that might ensure the safety of the mother, the child and themselves. I also argue that government health professionals and officials' prohibition of the practices of TBAs will only put the lives of women in danger. As one of the FGD participants has duly noted, TBAs are the ones that accompany and aid women, in the absences of ambulances and medical health care workers and when women and their families travel to the health facility.

Since the earlier days of the Ethiopian health system, there seems to be a constant pressure between the effort to push back against development and modernization discourses in some aspects while simultaneously accepting and promoting it in other ways. Nineteenth and twentieth-century Ethiopian emperors resisted political and economic colonization that impacted the health system. They were skeptical of foreigners (British and Italian) who were attempting to set up colonial health systems that would only benefit colonizers and foreigners in Ethiopia. On the other hand, the emperors were very keen on introducing western medicine and medical technologies to the population. Similarly, the current government, despite the global economic development discourse in which it has emerged, has to a certain extent, tried to challenge the privatization of its health services and maternal health care. An example of such efforts under the SWAP framework includes the recent decision to make child delivery costs free for all women. However, despite such positive efforts the current health system continues to favor biomedical solutions and global development and population control frameworks that undermine the reproductive desires and needs of women and their community-based

maternal health knowledge and practices. This paradox makes the experience of the nation as a whole and women, in particular, a complex one.

I argue that despite the efforts underway and regardless of what the government and UN estimates claim, maternal mortality rates and maternal health complications have not improved significantly (Berhan & Berhan, 2014; Tessema et al., 2017). National policies related to maternal health all focus on family planning, facility-based delivery and the education of women and their communities. A facility-based delivery strategy in a context where women prefer to deliver at home and in the absence of medical professionals, medical equipment and other resources seems disconnected with the actual needs and demands of women. Similarly, a reproductive health and population policy that mainly focuses on encouraging Ethiopian women to reduce fertility for the sake of development does not seem to take into account their current socio-cultural and economic context in the rural setting where women are valued as mothers and where children are a source of honor, labor and social security. As noted earlier, numerous studies have proved that better living standards and improved economic conditions of the masses lead to better health outcomes and population stabilization (Hartmann, 1995). Population issues should be addressed in relation to the underlying social and economic problems the population at large and women, in particular, are facing.

Moreover, government policies and strategies that assume that women are unaware of family planning and maternal health services and that promote the education of girls and women as a solution for reproductive health challenges need to be redesigned with context-specific interventions that will address women's actual reproductive and maternal health needs and their social and economic conditions. Health and development

strategies that are based on a neoliberal, western-modeled education of women and girls and their communities at large fail to understand the socio-cultural and economic conditions women, girls and their families reside in. As discussed in chapter four parents' decision not to send their children to school is related to their need for labor for the subsistence agriculture that they are engaged in and on which the entire nation depends on for its consumption and export. Parents' decision is also tied to the socio-cultural ties and kinship they want to create through marriage and their fear of alienation of their children from the rural communities that they grew up in once they have gone to school.

Therefore, the provision of education at large and reproductive health education, in particular, must be tailored to the living conditions of the rural masses. Instead of a homogenized education and information system that does not take into account the socio-cultural specificities and economic conditions of women and their families, I argue for an education that will ease the burden on rural farmers' and their children's day to day lives. Education that particularly engages young girls to contribute to their communities' social and economic life while maintaining their socio-cultural ties might be suitable to avoid rural-urban migration, unemployment and further poverty for women. This is easier said than done since in the past two centuries education in Ethiopia has taken a western model of development that has not done much to change the traditional, arduous rural farming activities of farmers.

As I have noted in chapter four, understanding and recognizing women's reproductive beliefs, rituals and cultural practices help improve maternal health services. The government needs to design health strategies that specifically address socio-cultural ties beyond the legal enforcement measures that work to eradicate or stop customary

marriages and indigenous reproductive and maternal health practices and rituals. Customary marriages and traditional birth practices will continue to occur despite legal restrictions. The government should conduct in-depth studies on the root causes and reasons behind the traditional practices and rituals related to marriage, pregnancy and childbirth. The policies and implementations should include dialogue with the community about these socio-cultural beliefs and practices so that a collective decision on how best to improve the maternal health of women can be made in these contexts.

As discussed in chapter four, Amhara and Oromo women should be informed about the harmful effects of the modern family planning methods that are being administered in their areas. Moreover, the health complications and side effects that result from these hormonal drugs should be taken seriously. Contrary to what health professionals and government policies assume about women's knowledge of family planning services, women and their communities make informed and conscious decision about when and how to give birth and how to limit their pregnancies based on their socio-cultural and economic conditions and the health services that are made available to them. Family planning services should not lack the necessary information to make conscious decisions.

Despite the comprehensive reproductive health paradigm post-ICPD that Ethiopia has incorporated into the health policy, the nation has still not designed strategies to involve men in maternal health service provision. The findings both from this study and my previous research reveal the presence of varied forms of masculinities in addition to the usually narrated hegemonic, patriarchal and dominant roles of men in various reproductive health research texts. I argue that these alternative forms of masculinities

can serve as entry points for bringing about social and behavioral change. They also can be employed to create community and government based initiatives for maternal health emergencies that are legitimized and supported by men and women in the community.

Policy Shifts and Potentials for Change

Amidst all the challenges and gaps that I have discussed in maternal health services provision, there are some policy shifts and small community-based government interventions underway that need to be acknowledged and promoted. Participants from both regions have also acknowledged the benefits of these services and approaches to maternal health. Although not adequate, the mere fact that delivery costs have become free for women in the past few years is a tremendous achievement for a poor nation like Ethiopia. When women decide to use health services in times of emergency, major reasons for delay were delivery and other hospital costs. Another improvement worth noting is the effort to provide emergency transportation (ambulance). Again, even though the ambulance service is not adequate, the fact that the government has started it and communities have taken ownership of the initiative points to the need for such transportation services and the usefulness of the approach. Recent studies note that effective and adequate use of ambulance services have improved maternal health outcomes in other districts where high maternal mortality has been recorded (Hagos et al., 2016).

With all the challenges and gaps, another positive shift is the government's community-based approach. The gender-sensitive HEW and HDA approaches have provided employment for many women. Potential policy shifts and interventions underway such as the use of coffee ceremonies by HDAs (with due regard to political

bias of participating in these groups) and the construction of maternal social spaces in health facilities can be replicated and enhanced in all regions to address maternal health issues. The government's recent activities in some Woredas to include community practices in health service delivery should also be replicated. In addition to the maternal waiting rooms that are under construction, simple ceremonies such as the preparation of *Genfo* might make women feel at home. These government initiatives to integrate community-based practices into health service delivery by creating maternal social spaces, conducting coffee ceremonies and other cultural practices are commendable and need to be encouraged. These are interventions that women and their communities have approved of in our discussion of the possible ways forward.

Finally, I would like to conclude with some solutions that women and their communities have discussed. Participants strongly emphasized the role of TBAs in childbirth and their assistance when women and their families travel to the health facilities. Participants in Amhara and Oromia criticized the legal and policy measures taken to stop TBAs. They have asked for the support and assistance of TBAs as well as health care professionals. Participants in the FGDs and interviews from both regions also recommended that the government should increase the number of ambulances, build roads and infrastructures and help them in expanding the water supply in their areas. The community members have noted that they have collected contributions from each household and have provided the local government offices with their resources. Community members have also offered to assist with labor in the construction and improvement of roads and other health infrastructures.

Socially, participants noted that they as a community need to help women and specifically pregnant women by sharing their workload and that men should assist women in the house. They also noted that women should be able to decide to space pregnancies. In addition, community members also discussed the use of community-based organizations such as *Edir, Equb* and *Mahiber* for assistance in times of maternal emergencies. In Oromia women interviewees discussed about an association of twenty-one women who help each other by lending money to an expectant mother during the days of her delivery as an emergency fund and the money will be returned fifteen days after her delivery. Such emergency funds schemes can be replicated in other places as well.

Overall all the examination of development and modernization narratives in maternal health service provision and the integration of local community based reproductive knowledge is useful to bring about effective change in a context where majority of women live in rural areas and prefer to deliver at home. In addition, examining the socio-cultural and economic context in which childbirth occurs will allow the government to design context specific maternal health policies. Such in-depth investigation will allow the government to design programs that are not just focused on family planning, fertility reduction and facility-based delivery but the provision of reproductive health services that take into account the knowledge and needs of Amara and Oromo women which at the moment primarily consists of having children and a safe home delivery.

REFERENCES

Abbasi, K. (2014). The world health organization: No game of thrones. *BMJ (Online), 348* doi:10.1136/bmj.g4265

Abdella, A. (2010). *Maternal mortality trend in ethiopia*. Ethiopian Journal of Health Development, 24 Special Issue 1, 115-122.

Adjiwanou, V., & LeGrand, T. (2014). Gender inequality and the use of maternal healthcare services in rural sub-Saharan Africa. *Health & Place, 29*(0), 67-78. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1016/j.healthplace.2014.06.001

African Development Fund [ADF], 1997. *Federal democratic republic of ethiopia: Structural adjustment program project completion report.* Country Department Eastern Region (OCDE)

Aguinaga, M., Lang, M., Mokrani, D., & Santillana, A. (2013). Critiques and alternatives to development: A feminist perspective. In M. Lang, & D. Mokrani (Eds.), *Beyond development : Alternative vision from latin america* () The Transnational Institute.

Alarcón, N., & Moallem, M. (1999). *Between woman and nation: Nationalisms, transnational feminisms, and the state* Duke University Press.

Alcoff, L. (2006). *Visible identities :Race, gender, and the self*. New York: Oxford University Press.

Alemayehu, T., Haider, J., & Habte, D. (2010). Determinants of adolescent fertility in ethiopia. *Ethiopian Journal of Health Development, 24*(1), 30-38.

Alemayehu, M., & Mekonnen, W. (2015). The prevalence of skilled birth attendant utilization and its correlates in north west ethiopia. *BioMed Research International, 2015*, 1-8. doi:10.1155/2015/436938

Alva, S. (2012, May). *Gender attitudes and male involvement in maternal health care in Rwanda*. Retrieved from http://paa2012.princeton.edu/papers/122454

Anderson, F. W. J. (2009). Maternal mortality: An enduring epidemic. *Clinical Obstetrics and Gynecology, 52*(2), 214-223. doi:10.1097/GRF.0b013e3181a4bd53

Ansong, E. (2015). The association between household consumer durable assets and maternal health-seeking behavior in ghana. *Women & Health, 55*(5), 485-504. doi:10.1080/03630242.2015.1022815

Ayele, D. (2015). Determinants of fertility in ethiopia. *African Health Sciences, 15*(2), 546-550. doi:10.4314/ahs.v15i2.29

Ayittey, G. B. N. (1998). *Africa in chaos* (1st St. Martin's ed.). New York: St. Martin's Press.

Barker, G. (2006). *Engaging boys and men to empower girls: Reflection from practice and evidence of Impacts.* Florence, Italy: United Nations Divisions for the Advancement of Women and UNICEF.

Barker, G., & Das, A. (2004). Men and Sexual and Reproductive health: The sexual revolution. *International Journal of Men's Health, 3*, 147-153.

Barua, A., Pande, R. P., MacQuarrie, K., & Walia, S. (2004, December 25-31). Caring Men? Husbands' Involvement in Maternal Care of Young Wives. *Economic and Political Weekly , 39*, 5661-5668. Retrieved from http://www.jstor.org/stable/4415985.

Bazuaye, A., & Okonofua, F. (2013). Tackling maternal mortality in africa after 2015: What should the priorities be? *African Journal of Reproductive Health, 17*(2), 9.

Bedford, J., Gandhi, M., Admassu, M., & Girma, A. (2013). 'A normal delivery takes place at home': A qualitative study of the location of childbirth in rural ethiopia. *Maternal and Child Health Journal, 17*(2), 230-239. doi:10.1007/s10995-012-0965

BenerÍa, L., Floro, M., Grown, C., & MacDonald, M. (2000). Introduction: Globalization and gender. *Feminist Economics, 6*(3), vii-xviii. doi:10.1080/135457000750020100

Benova, L., Campbell, O. M. R., & Ploubidis, G. B. (2014). Socio-economic gradients in maternal and child health-seeking behaviours in egypt: Systematic literature review and evidence synthesis. *PloS One, 9*(3), e93032

Berhane, Y., Gossaye, Y., Emmelin, M., & Hogberg, U. (2001). Women's health in a rural setting in societal transition in Ethiopia. *Social Science & Medicine (1982), 53*(11), 1525-1539.

Berhan, Y., & Berhan, A. (2014). Review of maternal mortality in ethiopia: A story of the past 30 years. *Ethiopian Journal of Health Sciences, 24 Suppl*, 3-14.

Bishaw, M. (1991). Promoting traditional medicine in ethiopia: A brief historical review of government policy. *Social Science & Medicine, 33*(2), 193-200. doi:10.1016/0277-9536(91)90180-K

Bove, R., & Valeggia, C. (2009). Polygyny and women's health in sub-saharan africa. *Social Science & Medicine, 68*(1), 21-29. doi:10.1016/j.socscimed.2008.09.045

Bridges, K. M. (2011). *Reproducing race: An ethnography of pregnancy as a site of racialization*. Berkeley, CA, USA: University of California Press.

Briggs, L. (2002). *Reproducing empire : Race, sex, science, and U.S. imperialism in puerto rico*. Los Angeles: University of California Press.

Brown, A. M. (2006). WID and GAD in dar es salaam, tanzania: Reappraising gender planning approaches in theory and practice. *Journal of Women, Politics & Policy, 28*(2), 57-83. doi:10.1300/J501v28n02_03

Browner, C. H., & Sargent, C. F. (2011). *Reproduction, globalization, and the state: New theoretical and ethnographic perspectives*. Durham N.C.: Duke University Press.

Butler, J. (2004). *Undoing gender*. New York: Routledge.

Carr, M., Chen, M. A., & Tate, J. (2000). Globalization and home-based workers. *Feminist Economics, 6*(3), 123-142. doi:10.1080/135457000750020164

Carter, M. (2002). Husbands and maternal health matters in rural Guatemala: wives' reports on their spouses involvement in pregnancy and birth. *Social Science & Medicine , 55*, 437–450

Cassels, A. (1997). *A guide to sector wide appraoches to health development :Concepts issues and working arrangments* World Health Organization.

Chambers, R. (1983). *Rural development :Putting the last first*. London; New York: Longman.

Chant, S. (2016). Galvanizing girls for development? critiquing the shift from "smart' to "smarter economics'. *Progress in Development Studies, 16*(4), 314-328. doi:10.1177/1464993416657209

Chen, J. (2011). Globalizing, Reproducing, and Civilizing Rural Subjects: Population Control Policy and Constructions of Rural Identity in China. In C. H. Browner and C. F. Sargent (Eds.), *Reproduction, Globalization, and the State: New Theoretical and Ethnographic Perspectives* (pp. 38-52). Durham and London, Duke University Press.

Chilisa, B. (2012). *Indigenous research methodologies*. Thousand Oaks, Calif.: SAGE Publications.

Chintu, M. K., & Susu, B. (1994). Role of the midwife in maternal health care. In B.T. Nasah, J.K.G. Mati & J.M. Kasonde (Eds.), *Contemporary issues in maternal health care in Africa* (pp. 101-122). World Health Organization, Geneva, Switzerland.

Choguya, N. Z. (2014). Traditional birth attendants and policy ambivalence in zimbabwe. *Journal of Anthropology, 2014*, 1-9. doi:10.1155/2014/750240

Collins, P. H. (1986). Learning from the outsider within: The sociological significance of black feminist thought. *Social problems*, 14-32.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Psychology Press.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society*, *19*(6), 829-859. doi:10.1177/0891243205278639

Connell, R. (2005). *Masculinities* (2nd ed.). Berkeley, Calif: University of California Press.

Connelly, M. J. (2008). *Fatal misconception :The struggle to control world population*. Cambridge, Mass.: Belknap Press of Harvard University Press.

Conrad, P. (2007). *Medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore, MD, USA: Johns Hopkins University Press.

Cooper, F. (2010). Writing the history of development. *Journal of Modern European History*, *8*(1), 5-23.

Cooper, F., & Packard, R. M. (1997). International development and the social sciences: Essays on the history and politics of knowledge. Retrieved from http://asu.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwdV3JCsIwEB0UDwoeXCouFfIDlTYxNTmLRW8i3kvaNMde9P9xYpu4oMc0kNKQ2V7nvQAwuomjL5QSF6kdIuOoRRGCGunRSF5bFKFKUApP__MeNUcB7y99ep48IJxrBQsc6uL7tXmQaeLB1esChWacsNNxYQIi4Dd22DHWkdN_k1tnLB7oqZNtJkIwheHDxy9tFlDJ2qnkDf8YhvU0gwDyiX90_RNWaYGJHGkCctFHuFkCYHa77Y4QvzVvcJndfyOkMhsr2u9f3Jy9Oz4EIVZrUMEO5FmiDWlYFlh5iK2OlRcLUAoKfay3_PF_BoBFmteBCCD2Dh79aP3fhAfS3evs

Cornwall, A., Edstro¨m, J., Greig, A., & MyiLibrary. (2011). *Men and development: Politicizing masculinities*. New York: Zed Books.

Corradi, L., & Vingelli, G. (2008). Women's health transnational networks. *Societies without Borders*, *3*(2), 228-247. doi:10.1163/187219108X300028

CSA [Central Statistical Agency]. (2007). Population and Housing Census of Ethiopia 2007. CSA and ICF International Calverton, Maryland: USA.

CSA [Central Statistical Agency]. (2012). *Ethiopia demographic and health survey 2011: Key findings*. Maryland: USA: CSA and ICF International Calverton.

CSA, [Central Statistical Agency]. (2013). *Ethiopian welfare monitoring survey 2011. Statistical report:Indicators on living standard, accessibility and household assets.* CSA and ICF International Calverton, Maryland: USA.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum,* 139.

Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health, 94*(11), 1864-1874. doi:10.2105/AJPH.94.11.1864

Damtew, Z. A., Moges, A. S., & Kaasbøll, J. (2012). Revisiting the quality of health extension workers' training: Case study from amhara region, ethiopia. *Ethiopian Journal of Health Development, 25*(3), 201-205.

Deressa, Y. (1967). *History of ethiopia: Sixteenth century.* Berhan and Selam Printing Press. (Amharic).

Deressa, B. (2003). *Oromtitti: The forgotten women in ethiopian history*. Raliegh North Carolina: Ivy House Publishing Group.

Diaz, V. M. (2011). Tackling Pacific Hegemonic Formations on the American Gridiron. *Amerasia Journal special issue, 37*(3), 90-113.

Dick-Read, G., Ellis, H. F., & Wessel, H. (1984). *Childbirth without fear: The original approach to natural childbirth* (5th ed.). New York: Harper & Row.

Diniz, S. (2012). Materno-infantilism, feminism and maternal health policy in brazil. *Reproductive Health Matters, 20*(39), 125-132. doi:10.1016/S0968-8080(12)39616

Dudgeon, M. R., & Inhorn, M. C. (2004). Men's influences on women's reproductive health: Medical anthropological perspectives. *Social Science & Medicine, 59*(7), 1379-1395. doi:10.1016/j.socscimed.2003.11.035

Dyer, S. J. (2007). The value of children in african countries: Insights from studies on infertility. *Journal of Psychosomatic Obstetrics and Gynecology, 28*(2), 69-77. doi:10.1080/01674820701409959

Elias, J., & Beasley, C. (2009). Hegemonic Masculinity and Globalization: 'Transnational Business Masculinities' and Beyond, Globalizations. *6*(2), 281-296. doi:10.1080/14747730902854232

Emire, Y. (2009). *Analysis of gender relations as reflected in Amharic proverbs and oral poems of West Gojjam Zone*. (Unpublished Thesis for the Master of Arts in Literature). Ethiopia: Addis Ababa University.

Evans, I. (1995). SAPping maternal health. *The Lancet, 346*(8982), 1046-1046. doi:10.1016/S0140-6736(95)91733-0

FAO. (2013). *Women feed the world*. Retrieved from http://www.fao.org/docrep/x0262e/x0262e16.htm#TopOfPage.

FDRE, Federal Democratic Republic of Ethiopia. (1993)**.** *National population policy of ethiopia*. Office of the Prime Minister Addis Ababa: Ethiopia. Retrieved from https://cyber.harvard.edu/population/policies/ETHIOPIA.htm

Federal Democratic Republic of Ethiopia (FDRE). (1994). *The constitution of the federal democratic republic of Ethiopia.* Addis Ababa

FMOH, Federal Ministry of Health. (1998). *Health sector development programme implementation manual.* Ethiopia

FMOH, Federal Ministry of Health. (2006). *The national reproductive health strategy.* (2006-2015). Ethiopia: Federal Democratic Republic of Ethiopia Ministry of Health.

FMOH, Federal Ministry of Health. (2009). *Joint mission report final*. EFY 2001.

FMOH, Federal Ministry of Health. (2010). Health sector development program *HSDP IV*. (2010/11-2014/2015).

FMOH, Federal Ministry of Health. (2013a). *HSDP IV annual performance report*. EFY 2006 (2013/2014). Version 1.

FMOH, Federal Ministry of Health. (2013b*). 15th annual review meeting: The last lap towards MDGs promise renewed to end preventable maternal and child health issues in Ethiopia.* EFY 2006 (2013/2014).

FMOH, Federal Ministry of Health. (2015a). *HSDP IV annual performance report*. EFY 2007(2014/2015).

FMOH, Federal Ministry of Health. (2015b). *Factsheet ethiopia - 2015*. Retrieved from http://www.moh.gov.et/factsheets

FMOH, Federal Ministry of Health. (2016). *HSTP IV annual performance report*. EFY 2008 (2015/2016)

Filippi, V. et.al. (2009). *Maternal health in poor countries: the broader context and a call for action*. Maternal Survival 5. Lancet, 368, 1535–41.

Fort, M. P., Mercer, M. A., & Gish, O. (2004). *Sickness and wealth: The corporate assault on global health* (1st ed.). Cambridge, Mass: South End Press.

Foster, M., Nachod, F.(2000). *Expenditure framework and partnership.* OED Working paper Series No.9.

Fraser, G. J. (1998). *African american midwifery in the south: Dialogues of birth, race, and memory*. Cambridge, Mass.; London: Harvard University Press.

Gebre, A. (2012). Migration patterns of children exposed to sexual exploitation in selected zones of Ethiopia. *Journal of Children's Services,* Vol. 7 (4), 262 – 274.

Gebremedhin, T. A., & Mohanty, I. (2016). Child schooling in ethiopia: The role of maternal autonomy. *PLoS One, 11*(12), e0167639. doi:10.1371/journal.pone.0167639

Getahun, A. S., & Balcha, A. (2012). Indigenous healing practices in ethiopia. In E. Mehari , K. Gebeyehu & Z. Asfaw (Eds.), *The manual of ethiopian medical history* (pp. 15) People to people Inc.

Gibson, M. A., & Mace, R. (2007). Polygyny, reproductive success and child health in rural ethiopia: Why marry a married man? *Journal of Biosocial Science, 39*(2), 287-300. doi:10.1017/S0021932006001441

Gilmore, L. (2005). Autobiography's wounds. In W. Kozol, & W. Hesford (Eds.), *Just advocacy?: Women's human rights, transnational feminisms, and the politics of representation* (pp. 99-119). New Brunswick, NJ: Rutgers University Press.

Ginsburg, F., & Rapp, R. (1991). The politics of reproduction. *Annual Review of Anthropology, 20*, 311-343.

Ginsburg, F., & Rapp, R. (1995). *Conceiving the new world order: The global politics of reproduction*. Berkeley, CA: University of California Press.

Girma, Y. (2008). *Obstetric fistula in the lives of women: The case of fistula patients under treatment at the Addis Ababa Fistula Hospital.* Addis Ababa: Institute of Gender Studies AAU Press.

Gish, O. (2004). The legacy of colonial medicine. In M. P. Fort, & O. Gish (Eds.), *Sickness and wealth : The corporate assualt on global health* (1st ed ed.,). Cambridge, Mass: South End Press.

Glenn, E. N., Chang, G., & Forcey, L. R. (1994). *Mothering: Ideology, experience, and agency*. New York: Routledge.

Gloyd, S. (2004). Sapping the poor: The impact of structural adjustment programs. In M. P. Fort, O. Gish & M. A. Mercer (Eds.), *Sickness and wealth: The corporate assualt on global health* (1st ed.,). Cambridge, Mass: South End Press.

Greenhalgh, S. (1995). *Situating fertility :Anthropology and demographic inquiry*. Cambridge England; New York, NY, USA: Cambridge University Press.

Grewal, I., & Kaplan, C. (2001). Global identities: Theorizing transnational studies of sexuality.
GLQ: A Journal of Lesbian and Gay Studies, 7(4), 663-679.

Grown, C., Braunstein, E., & Malhotra, A. (2006). *Trading women's health and rights?: Trade liberalization and reproductive health in developing economies*. London: Zed Books.

Gruskin, S., Cottingham, J., Hilber M., A., Kismodi, E., Lincetto, O., & Roseman, J.,Mindy. (2008). Using human rights to improve maternal and neonatal health: History, connections and a proposed practical approach. *Bulletin of the World Health Organization, 86 Number 8*(Past issues), 577-656.

Gurmu, E., & Dejene, T. (2012). Trends and differentials of adolescent motherhood in ethiopia: Evidences from 2005 demographic and health survey. *African Journal of Reproductive Health, 16*(4), 162-174.

Gurmu, E., & Mace, R. (2008). Fertility decline driven by poverty: The case of addis ababa, ethiopia. *Journal of Biosocial Science, 40*(3), 339-358. doi:10.1017/S002193200700260X

Hamer, J., & Hamer, I. (1966, October). EducationSpirit Possession and Its Socio-Psychological Implications among the Sidamo of SouthwestEthiopia. *Ethnology, 5*(4), 392-408. Retrieved from http://www.jstor.org/stable/3772719

Hancock, G. (1989). *Lords of poverty: The power, prestige, and corruption of the international aid business* (1st Atlantic Monthly Press ed.). New York: Atlantic Monthly Press.

Hannig, A. (2012). *The gift of cure: Childbirth injuries, clinical structures, and religious subjects in ethiopia.* (Unpublished doctoral dissertation).The University of Chicago. Retrieved from http://login.ezproxy1.lib.asu.edu/login?url=http://search.proquest.com/docview/1030961231?accountid=4485. (1030961231).

Harkiran Narang, & Seema Singhal. (2013). Men as partners in maternal health: An analysis of male awareness and attitude. *International Journal of Reproduction, 2*, 388-392. doi:10.5455/2320-1770.ijrcog20130925

Hartmann, B. (1995). *Reproductive rights and wrongs: The global politics of population control* (Rev ed.). Boston, Mass.: South End Press.

Hawkesworth, M. E. (2006). *Globalization and feminist activism* Rowman & Littlefield Publishers.

Hobart, M., & ebrary, I. (1993; 2002). *An anthropological critique of development: The growth of ignorance* (illustrat; 1 ed.). London: Routledge. doi:10.4324/9780203410219

Hong, E. (2004). The primary health care movement meets the free market. In M. P. Fort, O. Gish & M. A. Mercer (Eds.), *Sickness and wealth: The corporate assualt on global health* (1st ed.,). Cambridge, Mass: South End Press.

Hussein, J. W. (2004). *A cultural representation of women in the oromo society*. African Study Monographs, 25(3): 103-147. doi:http://www.africa.kyoto-u.ac.jp/kiroku/asm_normal/abstracts/pdf/26-2/26-2-1.pdf

Hussein, J. W. (2005). *The social and ethno-cultural construction of masculinity and femininity in african proverbs* African Study Monographs (2005), 26(2): 59-87. doi:http://www.africa.kyoto-u.ac.jp/kiroku/asm_normal/abstracts/pdf/26-2/26-2-1.pdf

Issac, Ephraim (2013). *Ethiopian orthodox täwahïdo church.* The Red Sea Press: New Jeresy.

Jaggar .M, A. (2008). *Just methods: An interdisciplinary feminist reader*. Paradigm: US.

Jalée, P. (1970). *The pillage of the third world* (1st Modern Reader paperback ed.). New York: Monthy Review Press.

Johnson, C., & MyiLibrary. (2014). *Maternal transition: A north-south politics of pregnancy and childbirth*. New York: Routledge, Taylor & Francis Group.

Kaba, M., Bulto, T., Tafesse, Z., Lingerh, W., & Ali, I. (2016). Sociocultural determinants of home delivery in ethiopia: A qualitative study. *International Journal of Women's Health, 8*, 93-102. doi:10.2147/IJWH.S98722

Kakaire, O. et.al (2011). *Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural uganda*. Reproductive Health, 8-12.

Kaplan, C., & Grewal, I. (2001). Global identities: Theorizing transnational studies of sexuality. *Gay Lesbian Quarterly, 7*(4), 663-679.

Kassaye, K. D., Amberbir, A., Getachew, B., & Mussema, Y. (2006). A historical overview of traditional medicine practices and policy in ethiopia. *Ethiop.J.Health Dev. 2006;, 20*(2), 127-134.

Kelbessa, W. (2013). The oromo conception of life: An introduction. *Worldviews, 17*(1), 60-76. doi:10.1163/15685357-01701006

Kitaw, Y., Teka, G., Meche, H., Hailemariam, D., & Fantahun, M. (Eds.). (2012). *The evolution of public health in ethiopia* (2nd Revised Edition ed.). Addis Ababa: Ethiopian Public Health Association (EPHA).

Koblinsky, M., Tain, F., & Gaym, A. (2010). Responding to the maternal health care challenge: The ethiopian health extension program. *Ethiop J Health Dev, 24*(1), 105-109.

Koblinsky, M. A. (2003). *Reducing maternal mortality: Learning from bolivia, china, egypt, honduras, indonesia, jamaica, and zimbabwe*. Washington, DC: World Bank.

Koblitz, A. H. (2014). *Sex and herbs and birth control: Women and fertility regulation through the ages*. Seattle, WA: Kovalevskaia Fund.

Kok, M., Kea, A., Datiko, D., Broerse, J., Dieleman, M., Taegtmeyer, M., & Tulloch, O. (2015). A qualitative assessment of health extension workers' relationships with the community and health sector in ethiopia: Opportunities for enhancing maternal health performance. *Human Resources for Health, 13*(1), 80-12. doi:10.1186/s12960-015-0077-4

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Toronto: University of Toronto Press.

Kozol, W. & Hesford, W. eds. (2005) *Just advocacy?: women's human rights, transnational feminisms, and the politics of representation*. New Brunswick, NJ: Rutgers University Press.

Laelago, T., Yohannes, T., & Lemango, F. (2016). Prevalence of herbal medicine use and associated factors among pregnant women attending antenatal care at public health facilities in hossana town, southern ethiopia: Facility based cross sectional study. *Archives of Public Health = Archives Belges De Santé Publique, 74*(7), 7.

Lappé, F. M., Collins, J., Rosset, P., & Institute for Food and Development Policy. (1998). *World hunger :12 myths* (2 fully rev a updat ed.). New York: Grove Press.

Lee, J. Z., & Feng, W. (1999). *One quarter of humanity :Malthusian mythology and chinese realities, 1700-2000*. Cambridge, Mass.; London: Harvard University Press.

Legesse, A. (1973). *GADA: Three approaches to the study of african soceity*. New York: Free Press.

Leonard, A. & Raju, S. (2000). *Men as supportive partners in reproductive health: Moving from rhetoric to reality*. Population Council.

Levine, D. N. (1966). The concept of masculinity in ethiopian culture. (SAGE, Ed.) *International Journal of Social Psychiatry*, 112-117. Retrieved from http://isp.sagepub.com/content/12/1/17.refs.html

Levine, D. N. (2000). *Greater ethiopia: The evolution of a multiethnic society*. Chicago: University of Chicago Press.

Levine, D.N. (2005). The masculinity ethic and the spirit of warriorhood in ethiopian and japanese cultures. *International Journal of Ethiopian Studies, 2*(1/2), 161-177.

Lincove, J. A. (2009). Are markets good for girls? the world bank and neoliberal education reforms in developing countries. *The Whitehead Journal of Diplomacy and International Relations, 10*(1), 59-75.

Lister, S. (1998). *Implementing sector development programmes in ethiopia.* World Bank.

Lorde, A. (1984, 2007). In Clarke C. (Ed.), *Sister outsider: Essays and speeches.* (2007th ed.). USA: Crossing Press Feminist Series.

Marsahll, C. & Rossman, G.B. (2006) *Designing qualitative research*. India: Sage Publications.

McRobbie, A. (2009). *The aftermath of feminism: Gender, culture and social change.* Los Angeles: SAGE.

Meade, T., & Walker, M. (1991). *Science, medicine, and cultural imperialism*. New York: St. Martin's Press.

Mehari, E., Gebeyehu, K., & Asfaw, Z. (2012). *The manual of ethiopian medical history*. People to people Inc.

Mekuria, T, T. (1969). *Ethiopian history: From emperor libne dingil to emperor theodros*. Berhan and Selam Printing Press. (Amharic).

Mekuria, A. B., Erku, D. A., Gebresillassie, B. M., Birru, E. M., Tizazu, B., & Ahmedin, A. (2017). Prevalence and associated factors of herbal medicine use among pregnant women on antenatal care follow-up at university of gondar referral and teaching hospital, ethiopia: A cross-sectional study. *BMC Complementary and Alternative Medicine, 17*(1) doi:10.1186/s12906-017-1608-4

Mertens, D. M., Cram, F., Chilisa, B., & ebrary, I. (2013). *Indigenous pathways into social research: Voices of a new generation*. Walnut Creek, Calif: Left Coast Press.

Moallem, M. (2005). *Between warrior brother and veiled sister: Islamic fundamentalism and the politics of patriarchy in iran*. Berkeley: University of California Press.

MOFED [Ministry of Finance and Economic Development]. (2009). *Population and development indicators 2008.* Federal Democratic Republic of Ethiopia. Addis Ababa.

MOFED [Ministry of Finance and Economic Development]. (2010). *Growth and transformation plan 2010/11-2014-15.* Federal Democratic Republic of Ethiopia. Addis Ababa.

Mohanty, C. T. (2003). *Feminism without borders: Decolonizing theory, practicing solidarity*. Durham N.C.; London: Duke University Press.

Murphy, M. (2016, Fall 2012/ Spring 2013).The girl: Mergers of feminism and finance in neoliberal times. *Gender, Justice and Neoliberal Transformations,* (11.1-11.2), December 03 2016. doi:http://sfonline.barnard.edu/gender-justice-and-neoliberal-transformations/the-girl-mergers-of-feminism-and-finance-in-neoliberal-times/

Morsy, S. (1995). Deadly reproduction among Egyptian women: Maternal mortality and the medicalization of population control. In F.D. Ginsburg & R. Rapp (Eds.), *Conceiving the new world order: The global politics of reproduction* (pp. 162-176). Berkeley, CA: University of California Press.

Nanda, P. (2006). I would pay, if I could pay in maize: Trade liberalization, user fees in health and women's health seeking in tanzania. in C. grown, E. braunstein & A. malhotra (eds.), In C. Grown, E. Braunstein & A. Malhotra (Eds.), *Trading women's health and rights?: Trade liberalization and reproductive health in developing economies* (pp. (pp. 191-208)). London New York: Zed Books.

Narayan, U. (1997). *Dislocating cultures: Identities, traditions and third world feminism*. New York: Routledge.

Nasah, B. T., Mati, J. K. G., & Kasonde, J. M. (1994). *Contemporary issues in maternal health care in africa*. Luxembourg; U.S.: Harwood Academic Publishers.

NCTPE, National Committee on Traditional Practices in Ethiopia. (2008). *Old beyond imaginings: Ethiopia harmful traditional practices*. 2nd edition. Ethiopia: EGLDAM.

Njikam, M. O. (1994). The management of maternal services in Africa: The socio-economic and cultural environment. In B.T. Nasah, J.K.G. Mati & J.M. Kasonde (Eds.), *Contemporary issues in maternal health care in Africa* (pp. 11-26). World Health Organization, Geneva, Switzerland.

Nnaemeka, O. (2004). Nego-feminism: Theorizing, practicing, and Pruning Africa's way. *Signs, 29*(2), 357-385.

Oas, R. (2015,). FDA blasts, WHO downplays, risks of depo-provera contraceptive. Retrieved from https://c-fam.org/friday_fax/fda-blasts-who-downplays-risks-of-depo-provera-contraceptive/

Owusu-Ansah, F. E., & Mji, G. (2013). African indigenous knowledge and research: original research. *African Journal of Disability*, *2*(1), 1-5.

Oyěwùmí, O. (1997). *The invention of women: Making an african sense of western gender discourses*. Minneapolis, MN: University of Minnesota Press.

Oyewumi, O. (2000). Family bonds/conceptual binds: African notes on feminist epistemologies. *Signs [H.W.Wilson - SSA], 25*(4), 1093.

Pacagnella, R. C., Cecatti, J. G., Osis, M. J., & Souza, J. P. (2012). The role of delays in severe maternal morbidity and mortality: Expanding the conceptual framework. *Reproductive Health Matters, 20*(39), 155-163. doi:10.1016/S0968-8080(12)3960-8

Pandolfelli, L. E., Shandra, J., & Tyagi, J. (2014). The international monetary fund, structural adjustment, and women's health: A cross-national analysis of maternal mortality in sub-saharan africa: Structural adjustment maternal mortality. *The Sociological Quarterly, 55*(1), 119-142. doi:10.1111/tsq.12046

Pankhurst R., (1965). The beginning of modern medicine in ethiopia. *Ethiopia Observer*, 9, pp. 114-160.

Pankhurst, R. (1998). *The ethiopians*. Malden, Mass; Oxford: Blackwell Publishers.

Parpart, J. L., Connelly, P., Barriteau, E., & ebrary, I. (2000; 2014). *Theoretical perspectives on gender and development*. Ottawa: International Development Research Centre.

Petchesky, R. P. (2003). *Global prescriptions: Gendering health and human rights*. London; New York: Zed Books.

Peters, D., Paina, L., & Schleimann, F. (2013). Sector-wide approaches (SWAps) in health: What have we learned? *Health Policy and Planning, 28*(8), 884-890. doi:10.1093/heapol/czs128

Pizurki, H., & Mangay-Maglacas, A. (1981). *The traditional birth attendant in seven countries: Case studies in utilization and training*. Geneva: World Health Organization.

Plantin, L., Olukoya, A. A., Ny, P., Sektionen för hälsa och samhälle, & Högskolan Kristianstad. (2011). Positive health outcomes of fathers' involvement in pregnancy and childbirth paternal support: A scope study literature review. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers, 9*(1), 87-102. doi:10.3149/fth.0901.87

Population Council. (2004). *Child marriage briefing: Ethiopia.* Population Council.

Prata, N., Gessessew, A., Cartwright, A., & Fraser, A. (2011). Provision of injectable contraceptives in ethiopia through community-based reproductive health agents. *Bulletin of the World Health Organization, 89*(8), 556-564. doi:10.2471/BLT.11.086710

Prosen, M. (2014). Sociological conceptualization of the medicalization of pregnancy and childbirth: The implications in slovenia. *Revija Za Sociologiju, 43*(3), 251-272.

Quarles van Ufford, P., & Giri, A. K. (2003). *A moral critique of development: In search of global responsibilities*. New York; London: Routledge. doi:10.4324/9780203451809

Randhawa, K. (2011). Ban this contraceptive implant pleads mother scarred for life. *Evening Standard*

Regassa, N. (2011). Antenatal and postnatal care service utilization in Southern Ethiopia: A population-based study. *African Health Sciences, 11*(3), 390.

Reminick, R. A. (1973). *The Manze Amhara of Ethiopia: A study of authority, masculinity, and sociality.* UMI Dissertation Services.

Rist, G., & ebrary., I. (2014). *The history of development from western origins to global faith* (Fourth; 4; 4th ed.). New York; London: Zed Books.

Roberts, D. E. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty* (1st ed.). New York: Pantheon Books.

Roro, M. A., Hassen, E. M., Lemma, A. M., Gebreyesus, S. H., & Afework, M. F. (2014). Why do women not deliver in health facilities: A qualitative study of the community perspectives in south central ethiopia? *BMC Research Notes, 7*, 556. doi:10.1186/1756-0500-7-556

Rosenfield, A. (1997). The history of the safe motherhood initiative. *International Journal of Gynecology and Obstetrics, 59*(2), S9-S9. doi:10.1016/S0020-7292(97)00141-0

Rosenfield, A., & Maine, D. (1985). Maternal mortality-a neglected tragedy. *The Lancet, 326*(8446), 83-85. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1016/S0140-6736(85)90188-6

Rothman, B. K. (2000; 1989). *Recreating motherhood*. New Brunswick, N.J.: Rutgers University Press.

Rubin, G. (1975). The traffic in women: Notes on the 'political economy' of sex: in Rayna Reiter, ed., *Toward Anthropology of Women*, New York, Monthly Review Press.

Sachs D., J. (2001). *Macroeconomics and health: Investing in health for economic development.* World Health Organization.

Sandisky, S. (2011). *Redesigning masculinity in the pursuit of reproductive health:* A Bachelors thesis submitted to the faculty of Wesleyan University.(Unpublished BA Thesis). Wesleyan University.

Sarker, B. K., Rahman, M., Rahman, T., Hossain, J., Reichenbach, L., & Mitra, D. K. (2016). Reasons for preference of home delivery with traditional birth attendants (TBAs) in rural bangladesh: A qualitative exploration: E0146161. *PLoS One, 11*(1) doi:10.1371/journal.pone.0146161

Semela, T. (2011). Vulnerability to brain-drain among academics in institutions of higher learning in ethiopia. *Asian Social Science, 7*(1), 3-18.

Shields, S. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*(5/6), 301.

Shinn. H , D.(2002). Reversing the brain drain in ethiopia. *Paper presented to Ethiopian North American Health Professionals Association*. George Washington University. Retrieved from http://chora.virtualave.net/brain-drain8.htm

Sharma, A. (2003). *Male involvement in reproductive health: Women's perspective.* The *Journal of Family Welfare*, Vol. 49, No.1.

Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., & Tekie, M. (2013). Why do women prefer home births in ethiopia? *BMC Pregnancy and Childbirth, 13*(1), 5-5. doi:10.1186/1471-2393-13-5

Shiva, V. (2010). *Staying alive: Women, ecology and development*. London: Zed Books. (Original Work Published in 1988)

Shiva, V. (2000). *Stolen harvest :The hijacking of the global food supply*. Cambridge, MA: South End Press.

Sipsma, H., Thompson, J., Maurer, L., Bradley, E., & Curry, L. (2013). Preferences for home delivery in ethiopia: Provider perspectives. *Global public health*, (ahead-of-print), 1-13.

Smith, L. T. (2012). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.). London; New York: Zed Books.

Sumner, C. 1995. *Oromo Wisdom Literature, I. Proverbs, Collection and Analysis.* Gudina Kumsa Foundation, Addis Ababa.

Switzer, H. (2013). (Post)feminist development fables: The girl effect and the production of sexual subjects. *Feminist Theory, 14*(3), 345-360. doi:10.1177/1464700113499855

Sychareun, V., Hansana, V., Somphet, V., Xayavong, S., Phengsavanh, A., & Popenoe, R. (2012). Reasons rural laotians choose home deliveries over delivery at health facilities: A qualitative study. *BMC Pregnancy and Childbirth, 12*(1), 86. doi:10.1186/1471-2393-12-86

Takeshita, C. (2012). *Global biopolitics of the IUD: How science constructs contraceptive users and women's bodies*. Cambridge, MA, USA: MIT Press.

Tarekegn, S. M., Lieberman, L. S., & Giedraitis, V. (2014). Determinants of maternal health service utilization in ethiopia: Analysis of the 2011 ethiopian demographic and health survey. *BMC Pregnancy and Childbirth, 14*(1), 161-161. doi:10.1186/1471-2393-14-161

Temesgen, T. M., Umer, J. Y., Buda, D. S., & Haregu, T. N. (2012). Contribution of traditional birth attendants to the formal health system in ethiopia: The case of afar region. *The Pan African Medical Journal, 13*, 15.

Teshome, G. (2001). *Problems and prospects for sector-wide approaches in health development: With an emphasis on the experience of ethiopia).* Unpublished manuscript. York University: England.

Tessema, G. A., Laurence, C. O., Melaku, Y. A., Misganaw, A., Woldie, S. A., Hiruye, A., Deribew, A. (2017). Trends and causes of maternal mortality in ethiopia during 1990-2013: Findings from the global burden of diseases study. *BMC Public Health, 17*(1) doi:10.1186/s12889-017-4071-8

Thomas, L. M. (2003). *Politics of the womb: Women, reproduction, and the state in kenya*. Berkeley, Calif: University of California Press. doi:10.1525/j.ctt1png1g

Tsegay, Y., Gebrehiwot, T., Goicolea, I., Edin, K., Lemma, H., & Sebastian, M. S. (2013). Determinants of antenatal and delivery care utilization in tigray region,

ethiopia: A cross-sectional study. *International Journal for Equity in Health, 12*(1), 30-30. doi:10.1186/1475-9276-12-30

Tsikata, D. (Fall 1995, Global Policy Forum). Effects of structural adjustment on. Retrieved from https://www.globalpolicy.org/component/content/article/218/46625.html

Uchendu, E. (2008). *Masculinities in contemporary Africa*. CODESREA, Gender series 7.

UNFPA, United Nations Fund for Population & Ethiopian Society of Population Studies. (2008). *Maternal mortality findings from EDHS 2005: An in-depth analysis of the ethiopian demographic and health survey 2005*. UNFPA.

Wagaw, T. G. (1990). *The development of higher education and social change*. East Lansing, Mich.: Michigan State University Press.

Wane, N. N. (2005). African indigenous knowledge: Claiming, writing, storing, and sharing the discourse. *Journal of Thought, 40*(2), 27-46.

Wane, N. (2008). Mapping the field of indigenous knowledges in anti-colonial discourse: A transformative journey in education. *Race, Ethnicity and Education, 11*(2), 183-197.

Wane, N., Kempf, A., & Simmons, M. (Eds.). (2011). *The politics of cultural knowledge*. Springer Science & Business Media.

WHO, World Health Organization. (1959). WHO chronicle. *WHO Chronicle,*

WHO, World Health Organization. (2009). *Milestones in health promotion: Statments in global conferences.*World Health Organization.

WHO, World Health Organization. (2013). *World health organization: Maternal health*. Retrieved from http://www.who.int/topics/maternal_health/en/

WHO, World Health Organization. (2014a). *Africa health observatory: Analytical summary -health financing system*. Ethiopia. Retrieved from http://www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Health_financing_system.

WHO, World Health Organization. (2014b). *Africa health observatory: Analytical summary -health system outcomes*. Ethiopia. Retrieved from http://www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Health_system_outcomes

WHO. (2014c). A*dolescent pregnancy: Fact sheet.* Retrieved from http://www.who.int/mediacentre/factsheets/fs364/en/. March 21, 2017

WHO, World Health Organization. 2015.*Ethiopia: Maternal Health*. Retrieved from http://www.afro.who.int/en/ethiopia/country-programmes/topics/4459-maternal-health.html

WHO, World Health Organization. 2016. *Maternal moratlity:Fact sheet*. Retrieved from http://www.who.int/mediacentre/factsheets/fs348/en/

Woldegiyorgis, A. A. (June 1, 2014). The ethiopian developmental state and its challenges. doi:Available at SSRN: https://ssrn.com/abstract=2512907 or http://dx.doi.org/10.2139/ssrn.2512907

Woldemariam, G., & Genebo, T. (2002). *Determinants of nutritional status of women and children in ethiopia.* Maryland USA: ORC Macro.

Woliver, L. R. (2002). *The political geographies of pregnancy*. Urbana: University of Illinois Press.

Zegeye, A., & Vambe, M. (2006). African indigenous knowledge systems. *Review (Fernand Braudel Center), 29*(4), 329-358.

Zelelew, H. (2012). Health care financing reform in ethiopia: Improving quality and equity. . *Abt Associates, 20(20), 2006-2011*.(Health Systems)

Zewde, B. (1991). *A history of modern ethiopia, 1855-1974*. Addis Ababa; London; Athens: J. Currey.

APPENDIX A

INTERVIEW QUESTIONS

INTERVIEW QUESTIONS

Individual Interview Questions for Women

Thank you for your time: I will ask you the following questions. Please feel free to explain your experiences and views in detail. If you feel uncomfortable to answer any of the questions, please stop and let me know.

Background / Demographic Information

1. Where were you born?
2. Where do you currently live?
3. What is your age?
4. What is your ethnicity?

Education

5. What do you think about education?
6. Have you ever attended formal education? If yes, how far have you gone? If no, did you ever want to attend formal education? Please explain your answer.
7. Have you ever attended non-formal education? If yes, what was the type of education? If no, did you ever want to attend non-formal education? Please explain your answer.
8. In your opinion what are the pros and cons of attending formal education for girls in this area?
9. How far do you have to travel to attend primary school in your area? How far do you have to go to attend secondary school?
10. Are there girls and boys in this area that do not go to school? How many girls and boys (estimate) do not go to school? If yes what is the reason that they do not attend? Is the reason for girls different from the reason for boys?
11. Who makes the decision to send children to school?

Income, Livelihood and Economic Conditions

12. What is the main source of income for your household?
13. What is your annual income?
14. What activities do you carry out to generate income? (Trade, farming etc…)
15. What type of assets (Land, cattle, house etc...) do you own as a family? What type of assets do you own personally?
16. Who has access to these assets from your household?
17. Who has control over these assets in your household? In other words who makes the decisions with regard to the selling, renting or use of these assets?
18. If you are engaged in farming what type of crops do you mainly produce? Do you produce for consumption or for the market or both? Please explain?
19. If you produce for the market, has the market for dairy products, farm commodities and the main crop you are producing changed over the past 5-10 years? How has it changed? How does it impact your livelihood?

20. If you produce for consumption on your farm what happens when there is a drought or shortage of rain etc..? How do you cope with these conditions?
21. If you do not farm for consumption where do you obtain the food for daily consumption? Do you face difficulties to acquire adequate food, water and other necessities to sustain the family? If so, what do you do to cope with such circumstances?
22. What are your daily chores? How long does it take you to get each task done? Do you have to travel? Who assists you when carrying out your daily chores? What time do you get up in the morning and what time do you go to bed at night?

Now let's talk about marriage

23. What does marriage mean in the context of your culture?
24. What is the main reason that people marry?
25. At what age are women expected to marry in your area? At what age are men expected to marry?
26. At what age (on average) do women actually marry in this community? At what age would a woman be considered late for marriage?
27. What happens when a woman or man does not marry? How is he/she perceived in the society?
28. How does your community view women who are married as compared to those who are not?
29. What are the expectations from a woman and from a man in the context of marriage?
30. Are you currently married? If not have you ever been married before?
31. When (at what age) did you get married? Did you want to get married at that time? Please explain.
32. Was the marriage arranged? If so please explain the process of arrangement?
33. Was there a consent process? If so who gave consent for the marriage to take place?
34. Do families and relatives play a role in the process of marriage?
35. How does marriage take place in this community? What are the processes, events, ceremonies that take place? Are there different ways to enter into marriage?
36. What are your roles and responsibilities as a married woman? What kind of activities do you carry out both within and outside the household?
37. What is the role and responsibilities of your husband in and outside the household? Does he engage in household activities?
38. What type of social activities do you engage in within the community as a married woman? Would you have engaged in these activities if you were not married? Why? Why not?

Now let us talk about the concepts of womanhood and manhood

39. In your opinion what is womanhood? What does it mean to be a woman in your community?
40. What does it mean to be a man in your community?
41. In your view what are the traits that are valued most in a woman and in a man in this community?
42. Give me examples of when a woman or a man is not considered as such?
43. When does a young girl transition into womanhood/adulthood? Are there ceremonies that mark this event in this area?
44. Similarly how does a young boy transition into adulthood?
45. Are there proverbs, saying or other stories told in your language that affirm notions of womanhood and manhood? Mention some that you can recall.
46. Who in these communities have influential roles in shaping notions of manhood and womanhood?

Religion

47. Do you follow any religious/spiritual belief? If so, what is your religion/spiritual belief?
48. How often do you attend religious events/ceremonies? How influential is your religious belief in the everyday decisions that you or your family make? Can you provide some examples?
49. Would you say that your religious beliefs have an influence on your view about child birth and maternity? How are they related? Please give me some example?
50. Who in the community has influential roles in religious or spiritual affairs?

Children, Contraception, Pregnancy and Processes of Childbirth

51. What does having a child mean in the cultural context of your community?
52. Do you have children? How many children do you have? Do you plan to have more children in the future? Please explain why or why not?
53. If you don't have children do you plan to have any in the near future? Why? Why not?
54. Do your children go to school? If yes what grades are they attending? If no what is the reason that they are not going to school?
55. What happens if a woman cannot have children?
56. Have you ever received any form of reproductive health education/information from health care professionals? What type of information did you receive?
57. Do you use family planning methods? If yes or no please explain why? If yes what method of family planning do you use? What is the reason you chose this method?
58. Are you aware of short-term (pills, condoms etc…) and long-term (IUD, Norplant, Depo-Provera etc…) modern family planning methods? How did you come to know about these methods? What were you informed? Were you informed about the advantages and disadvantages of these methods?

59. What is your view on short-term modern contraceptive methods? Are they available in your area? Have you ever used one? How was your experience? Who made the decision? Who administered the contraceptives?
60. What is your view on long-term provider controlled modern family planning methods? Are they available in your area? Have you ever used one? What was your experience? Who made the decision? Who administered the contraceptives?
61. Now let us talk about your last/most recent pregnancy experience. Was the pregnancy planned?
62. How was your overall health during your pregnancy? What type of foods did you eat during that time? Are there any food taboos during pregnancy? If, yes what are they and what is the reason?
63. Do you prefer traditional health services or going to the health centers? Why?
64. Do TBAs play a role in child delivery in this area? Please explain to me the various activities they carry out? Do you think their knowledge is valued in the community? Would you seek advice from TBAs for childbirth?
65. Have you ever visited the nearest health post/center for antenatal checkups? If yes, when was your most recent checkup? Were there any health challenges you faced during pregnancy or childbirth? If yes what was it and where did you go to address these health challenges?
66. Where did you give birth (where do you plan to give birth)? What was the reason you decided to give birth there? How was the delivery process? Who assisted you in the delivery? Please explain in detail what was done before, during and after delivery. Are these process common for women in this area?
67. How long were you in labor for? Were there any complications during delivery? If so what did you do? Did you seek help? Where did you seek help from?
68. What is the norm when women have health problems during pregnancy and delivery in this areas? What is the first thing that women do? Where do they seek help from?
69. Who makes the decision about health and financial issues in the household? When in labor do you have a say in the type of services that you seek?
70. Have you ever heard of anyone who has died in childbirth in your area? What were the conditions? Please explains.
71. Have you or anyone you know had a miscarriage? What were the circumstances?
72. What is done after delivery? How long do women rest? What are the traditional rituals during the postpartum phase?

Health Services, Policy, Roads and Infrastructure

73. How far is the nearest health service (health post, center, hospital) from where you live (in hours: on foot, by mule or using public transportation)?
74. How much does transportation (public transport/ manually carried stretchers) cost when traveling to the nearest health facility?

75. What kind of services does the nearest health facility provide? Does it provide basic and emergency obstetric care?
76. If the nearest health facility does not provide such services where do you go? How long do you have to travel to the next one?
77. What is the cost for maternal health services? How much does it cost (you can estimate) to deliver in a health facility?
78. How did you find the services provided by the health care professionals in your area? How is the attitude of the health care professionals towards the patients and their families? Are there any experiences of your own or others that you would like to share?
79. Who decides to seek health care in your household? What factors does the person making the decisions take into consideration?
80. Are women in this areas generally willing to visit health facilities during pregnancy? What is the reason?
81. Are you aware of the health care laws and policies of the nation? What do you know about the health care laws, policies of the nation? What has the government done in light of maternal health issues in your community?
82. Are you aware of the maternal mortality rates of the nation or your area? Have you noticed changes in the health service provision and in maternal health outcomes over the past decades? Please explain.
83. How are the conditions of the road in your area? Is it accessible by car/ ambulance in times of emergency? How long does it take to reach the asphalt road?
84. Are there rivers, hills and other terrains that you have to cross to get to the nearest health center? How many hours does it take? Can you please share your experience in detail?

Community based Interventions and Organizations

Now let's talk about various community organizations

85. Are there community based organizations or association in this area? What type of organizations are there? Do they serve the community in times of emergencies? Please mention them and explain their role?
86. Which of these organizations support pregnant women in times of emergencies? Are there community organizations specifically established to help women/mothers in times of need? Do you recall incidents where pregnant women were supported by such organizations?
87. Are you a member of any of these community organizations? Which of these are you a member of? What type of support have you received from these organizations?
88. Are there financial assistances offered in these organizations? How does the financial assistance work?

Recommendations

89. In your view what should the government do to improve maternal health outcomes?
90. What should be the main priority in terms of reproductive health for women in this community?
91. In your view what should improve in terms of maternal health services that are provided at your nearest health facilities? What do you think should be done to improve the reproductive health of women in this area?
92. What should change culturally, economically and politically to improve maternal health outcomes of women in this area.
93. In the future how can the community engage in addressing maternal health issues?

Thank you so much for taking the time to do this interview with me.

Individual Interview Questions for Men

Thank you for your time: I will ask you the following questions about maternal health issues and other general questions. Please feel free to explain your experiences and views in detail. If you feel uncomfortable to answer any of the questions, please stop and let me know.

Background / Demographic Information

1. Where were you born?
2. Where do you currently live?
3. What is your age?
4. What is your ethnicity?

Education

5. What do you think about education?
6. Have you ever attended formal education? If yes, how far have you gone? If no, did you ever want to attend formal education? Please explain your answer.
7. Have you ever attended non-formal education? If yes, what was the type of education? If no, did you ever want to attend non-formal education? Please explain your answer.
8. How far do you have to travel to attend primary school in your area? How far do you have to go to attend secondary school?
9. Are there girls and boys in this area that do not go to school? How many girls and boys (estimate) do not go to school? If yes what is the reason that they do not attend? Is the reason for girls different from the reason for boys?
10. In your opinion what are the pros and cons of having girls attend formal education in this area?
11. Who makes the decision to send children to school in your household?

Income, Livelihood and Economic Conditions

12. What is the main source of income for your household?
13. What is your annual income?
14. What activities do you carry out to generate income? (Trade, farming etc…)
15. What type of assets (Land, cattle, house etc...) do you own as a family? What type of assets do you own personally?
16. Who has access to these assets from your household?
17. Who has control over these assets in your household? In other words who makes the decisions with regard to the selling, renting or use of these assets?
18. If you are engaged in farming what type of crops do you mainly produce? Do you produce for consumption or for the market or both? Please explain?
19. If you produce for the market, has the market for dairy products, farm commodities and the main crop you are producing changed over the past 5-10 years? How has it changed? How does it impact your livelihood?
20. If you produce for consumption on your farm what happens when there is a drought or shortage of rain etc..? How do you cope with these conditions?
21. If you do not farm for consumption where do you obtain the food for daily consumption? Do you face difficulties to acquire adequate food, water and other necessities to sustain the family? If so, what do you do to cope with such circumstances?
22. What are your daily chores? How long does it take you to get each task done? Do you have to travel? Who assists you when carrying out your daily chores? What time do you get up in the morning and what time do you go to bed at night?

Now let's talk about marriage

23. What does marriage mean in the context of your culture?
24. What is the main reason that people marry?
25. At what age are women expected to marry in your area? At what age are men expected to marry?
26. At what age (on average) do women actually marry in this community? At what age would a woman be considered late for marriage?
27. What happens when a woman or man does not marry? How is he/she perceived in the society?
28. How does your community view women who are married as compared to those who are not?
29. What are the expectations from a woman and from a man in the context of marriage?
30. Are you currently married? If not have you ever been married before?
31. When (at what age) did you get married? Did you want to get married at that time? Please explain.
32. Was the marriage arranged? If so please explain the process of arrangement?
33. Was there a consent process? If so who gave consent for the marriage to take place?

34. Do families and relatives play a role in the process of marriage? How?
35. How does marriage take place in this community? What are the processes, events, ceremonies that take place? Are there different ways to enter into marriage?
36. What are your roles and responsibilities as a married man? What kind of activities do you carry out both within and outside the household?
37. What is the role and responsibilities of your wife in and outside the household?

Now let us talk about the concepts of manhood and womanhood

38. What does it mean to be a man in your community?
39. In your opinion what is womanhood? What does it mean to be a woman in your community?
40. In your view what are the traits that are valued most in a man and in a woman in this community?
41. Give me examples of when a woman or a man is not considered as such?
42. When does a young a young boy transition into adulthood? Are there ceremonies that mark this event in this area?
43. Similarly how does a young girl transition into womanhood/adulthood? Are there ceremonies that mark this event in this area?
44. Are there proverbs, saying or other stories told in your language that affirm notions of manhood and womanhood? Mention some that you can recall.
45. Who in these communities have influential roles in shaping notions of manhood and womanhood?

Religion

46. Do you follow any religious/spiritual belief? If so, what is your religion/spiritual belief?
47. How often do you attend religious events/ceremonies? How influential is your religious belief in the everyday decisions that you or your family make? Can you provide some examples?
48. Would you say that your religious beliefs have an influence on your view about child birth and maternity? How are they related? Please give me some example?
49. Who in the community has influential roles in religious or spiritual affairs?

Children, Contraception, Pregnancy and Processes of Childbirth

50. What does having a child mean in the cultural context of your community?
51. Do you have children? How many children do you have? Do you plan to have more children in the future? Please explain why or why not?
52. If you don't have children do you plan to have any in the near future? Why? Why not?
53. Do your children go to school? If yes what grades are they attending? If no what is the reason that they are not going to school?
54. What happens if a woman cannot have children?

55. Have you ever received any form of reproductive health education/information from health care professionals? What type of information did you receive?
56. Do you and your wife/partner use family planning methods? If yes or no please explain why? If yes what method of family planning do you use? What is the reason you chose this method?
57. Are you aware of short-term (pills, condoms etc…) and long-term (IUD, Norplant, Depo-Provera etc…) modern family planning methods? How did you come to know about these methods? What were you informed? Were you informed about the advantages and disadvantages of these methods?
58. What is your view on short-term modern contraceptive methods? Are they available in your area? Has your wife/partner ever used one? How was her experience? Who made the decision? Who administered the contraceptives?
59. What is your view on long-term provider controlled modern family planning methods? Are they available in your area? Have your wife/ partner ever used one? What was her experience? Who made the decision? Who administered the contraceptives?
60. Now let us talk about your wife/partner's last/most recent pregnancy experience. Was the pregnancy planned?
61. What was your role as a husband during the pregnancy, delivery and after the baby is born?
62. How was her health during the pregnancy?
63. Does your wife prefer traditional health services or going to the health centers? Why?
64. Do TBAs play a role in child delivery in this area? Please explain to me the various activities they carry out? Do you think their knowledge is valued in the community? Would you or your wife seek advice from TBAs for childbirth?
65. Did she ever visit the nearest health post/center for antenatal checkups? If yes, when was her most recent checkup? Whose decision was it? Were there any health challenges she faced during pregnancy or childbirth? If yes what was it and where did she go to address these health challenges?
66. Where did she give birth (where does she plan to give birth)? What was the reason that she decided to give birth there? How was the delivery process? Who assisted her in the delivery?
67. Please explain your role in the delivery process in detail?
68. How long was she in labor for? Were there any complications during delivery? If so what did you do? Did you seek help? Where did you seek help from?
69. In your opinion, what is the norm when women have health problems during pregnancy and delivery in this areas? What is the first thing that women do? Where do they seek help from?
70. Who makes the decision about health and financial issues in the household?
71. Have you ever heard of anyone who has died in childbirth in your area? What were the conditions? Please explains.

72. Has your wife/partner or anyone you know had a miscarriage? What were the circumstances?
73. What is your role in the postpartum phase?

Health Services, Policy, Roads and Infrastructure

74. How far is the nearest health service (health post, center, hospital) from where you live (in hours: on foot, by mule or using public transportation)?
75. How much does transportation (public transport/ manually carried stretchers) cost when traveling to the nearest health facility?
76. What kind of services does the nearest health facility provide? Does it provide basic and emergency obstetric care?
77. If the nearest health facility does not provide such services where do you go? How long do you have to travel to the next one?
78. What is the cost for maternal health services? How much does it cost (you can estimate) to deliver in a health facility?
79. How did you find the services provided by the health care professionals in your area? How is the attitude of the health care professionals towards the patients and their families? Are there any experiences of your own or others that you would like to share?
80. Who decides to seek health care in your household? What factors does the person making the decisions take into consideration?
81. Are women in this areas generally willing to visit health facilities during pregnancy? What is the reason?
82. Are you aware of the health care laws and policies of the nation? What do you know about the health care laws, policies of the nation? What has the government done in light of maternal health issues in your community?
83. Are you aware of the maternal mortality rates of the nation or your area? Have you noticed changes in the health service provision and in maternal health outcomes over the past decades? Please explain.
84. How are the conditions of the road in your area? Is it accessible by car/ ambulance in times of emergency? How long does it take to reach the asphalt road?
85. Are there rivers, hills and other terrains that you have to cross to get to the nearest health center? How many hours does it take? Can you please share your experience in detail?

Community based Interventions and Organizations

Now let's talk about various community organizations

86. Are there community based organizations or association in this area? What type of organizations are there? Do they serve the community in times of emergencies? Please mention them and explain their role?

87. Which of these organizations support pregnant women in times of emergencies? Are there community organizations specifically established to help women/mothers in times of need? Do you recall incidents where pregnant women were supported by such organizations?
88. Are you a member of any of these community organizations? Which of these are you a member of? What type of support have you received from these organizations?
89. Are there financial assistances offered in these organizations? How does the financial assistance work?

Recommendations

90. In your view what should the government do to improve maternal health outcomes?
91. What should be the main priority in terms of reproductive health for women in this community?
92. In your view what should improve in terms of maternal health services that are provided at your nearest health facilities? What do you think should be done to improve the reproductive health of women in this area?
93. What should change culturally, economically and politically to improve maternal health outcomes of women in this area.
94. In the future how can the community engage in addressing maternal health issues?

Thank you so much for taking the time to do this interview with me.

Focus Group Discussion Guide

Good Morning/ Afternoon: I would like to thank you for your time: Today we will discuss the following issues together. Feel free to explain your experiences and views in detail. Although I have come up with some themes for discussion we will not be rigid in our conversations; ideas and views that you feel are pertinent to maternal health issues that I may not have included here are welcome.

Demographic Information: Number of participants. Ask the following demographic information from each of the participants for data purposes**.** Social title (Religious leader, Traditional Birth Attendant, Youth representative etc), Place of Birth, Place of Residence, Age, Ethnicity

Education: Let's talk about education in this area

- What do you think about formal education?
- How far do you have to travel to attend primary school in your area? How far do you have to go to attend secondary school?
- Who makes the decision to send children to school?

- Are there girls and boys in this area that do not go to school? How many girls and boys (estimate) do not go to school? If yes what is the reason that they do not attend? Is the reason for girls different from the reason for boys?
- In your opinion what are the pros and cons of attending formal education for girls in this area?

Income, Livelihood and Economic Conditions

- What is the common form of livelihood in this area?
- Traditionally who has access and control over resources such as land, cattle, house in a household?
- How is the market for farm goods?
- How do families deal with issues of food insecurity?

Now let's talk about marriage

- What are the various social and cultural processes of marriage in this area? What does marriage mean in the context of your culture?
- What is the main reason that people marry?
- At what age are women expected to marry in your area? At what age are men expected to marry?
- At what age (on average) do women actually marry in this community? At what age would a woman be considered late for marriage?
- How does marriage take place in this community? What are the processes, events, ceremonies that take place? Are there different ways to enter into marriage?
- What are the expectations from a woman and from a man in the context of marriage? What are the roles and responsibilities for each of them?
- Who has a say in the marriage? Do families and relatives play a role in the process of marriage?
- What happens when a woman or man does not marry? How is he/she perceived in the society?

Now let us talk about the concepts of womanhood and manhood

- In your opinion what is womanhood? What does it mean to be a woman in your community?
- What does it mean to be a man in your community?
- In your view what are the traits that are valued most in a woman and in a man in this community?
- Give me examples of when a woman or a man is not considered as such?
- When does a young girl transition into womanhood/adulthood? Are there ceremonies that mark this event in this area?

- Similarly how does a young boy transitions into adulthood?
- Are there proverbs, saying or other stories told in your language that affirm notions of womanhood and manhood? Mention some that you can recall.
- Who in these communities have influential roles in shaping notions of manhood and womanhood?

Religion

- Tell me about the various religious/ spiritual belief that people have in this area. Would you say that religious beliefs have an influence on peoples' views about child birth and maternity? How? Please give me some example?
- Who in the community has influential roles in religious or spiritual affairs and how?

Contraception, Pregnancy and Processes of Childbirth

- What does having a child mean in the cultural context of your community?
- Are there cultural and traditional beliefs about fertility and birth? What are they?
- What happens if a woman cannot have children?
- What are your views about family planning methods? Do people use modern family planning methods?
- Are you aware of short-term (pills, condoms etc…) and long-term (IUD, Norplant, Depo-Provera etc…) modern family planning methods? What are your views on these methods? How did you come to know about these methods? What were you informed? Were you informed about the advantages and disadvantages of these methods?
- What are the norms here when women are pregnant?
- What is the norm when women have health problems during pregnancy and delivery in this areas? What is the first thing that women do? Where do they seek help from?
- Do TBAs play a role in child delivery in this area? Please explain to me the various activities they carry out and the roles they play in child delivery? Do you think their knowledge is valued in the community? Would you seek advice from TBAs for childbirth?
- Are women in this areas generally willing to visit health facilities during pregnancy? What is the reason? What would most women prefer traditional health services or going to the health centers? Why?
- Where do most women go to deliver their babies? Why do they choose that specific place? Who assists them in the delivery?
- Who makes the decision about health and financial issues in the household? When in labor do women have a say in the type of services that they seek?

- Have you ever heard of anyone who has died in childbirth in your area? What were the conditions? Please explains.
- What is done after delivery? How long do women rest? What are the traditional rituals during the postpartum phase?

Health Services, Policy, Roads and Infrastructure

- How far is the nearest health service (health post, center, hospital) from where you live (in hours: on foot, by mule or using public transportation)?
- If the nearest health facility does not provide maternal health services where do you go? How long do you have to travel to the next one?
- What kind of services does the nearest health facility provide? Does it provide basic and emergency obstetric care?
- What is the cost for maternal health services? How much does it cost to deliver in a health facility (you can estimate)?
- How much does transportation (public transport/ manually carried stretchers) cost when traveling to the nearest health facility?
- How are the services provided by the health care professionals in your area? How is the attitude of the health care professionals towards the patients and their families? Are there any experiences of your own or others that you would like to share?
- Are you aware of the health care laws and policies of the nation? What do you know about them? What has the government done in light of maternal health issues in your community?
- Are you aware of the maternal mortality rates of the nation or your area? Have you noticed changes in the health service provision and in maternal health outcomes over the past decades? What has changed? Please explain.
- How are the roads in your area? Can a car/ ambulance easily reach your neighborhood in times of emergency? How long does it take to reach the asphalt road?
- Are there rivers, hills and other terrains that you have to cross to get to the nearest health center? How many hours does it take? Can you please share your experience in detail?

Community based Interventions and Organizations: Now let's talk about various community organizations

- Are there community based organizations or association in this area that support pregnant women in times of emergency? What type of organizations are there? Please mention them and explain their role?
- How does the community help pregnant women in need? Do you recall incidents where pregnant women were supported by such organizations?

- What type of support do community organizations provide? Are there financial assistances offered in these organizations? How does the financial assistance work?

Recommendations

- What do you think should the government do to improve maternal health outcomes? What do you think should improve in terms of maternal health services that are provided at your nearest health facilities?
- What is the main priority in terms of reproductive health for women in this community? What do you think should be done to improve the reproductive health of women in this area?
- What do you think should change culturally, economically and politically to improve maternal health outcomes of women in these areas.
- In the future how can the community further engage in addressing maternal health issues? **Thank you so much for taking the time to discuss these issues with me.**

Interview Questions for Health Care Professionals and Administrators

Thank you for your time

Title/Position in the health care system_____ Gender_____
Training_____ Number of years served in the health care system_____

1. Please explain the various health policy focuses and program interventions that the government is currently undertaking with regard to reproductive health and specifically maternal health issues at the Federal/Regional/Woreda and Kebele level?
2. How is the government implementing these policies? What have been the successes? What have been the challenges?
3. Has grassroots/community organization been involved in the policy and program development? How has the community participated in the development and implementation process?
4. What are the main policy goals of the government when it comes to maternal health issues? How does it go about achieving these goals?
5. Where does the government obtain financial resources to undertake reproductive health programs? Does the government obtain resources from external sources? Who are the major funding entities? If so what are the terms and conditions on the use and managements of these funds?
6. How has the health finance reform policy impacted health services provisions in Ethiopia? What are the benefits and disadvantages?

7. What is the role of non-governmental organizations in policy development and health service provision?
8. What are the main maternal health challenges in Ethiopia? What are the causes of these challenges?
9. What is the main priority for women in terms of reproductive health in the nation? What are the reproductive desires and needs of women in Ethiopia? Does the policy resonate with their desires and needs? Why? Why not?
10. In your opinion do you think that the socio-cultural and economic contexts of women's lives have been taken into account when developing reproductive health programs? How? Can you give me some examples?
11. Is the reproductive knowledge of women in the community valued in the health care system? Why? Why not? If yes, how?
12. Where do most women in Ethiopia go to give birth? What do you think are the reasons for their choices?
13. How is the availability and accessibility of health facilities in the rural districts of Amhara and Oromia regions? Are there challenges in terms of availability and accessibility? Please explain. How does the government deal with such challenges?
14. What is the government's policies on family planning methods? How does that relate to maternal health services?
15. What does the policy state with regards to the role of men in reproductive health in general and specifically their role in maternal health issues?
16. What type of maternal health care services are provided at the Kebele level?
17. Which type of health professional (Physician, nurse, health assistant, health extension worker) is a woman living in rural Ethiopia most likely to come into contact with in her area? What type of training do these professionals receive? Do they perform basic and emergency obstetric care? Please explain.
18. What is the cost of maternal health services in these health facilities? What do women do when they are not able to afford these services?
19. What should be improved about the maternal health services in Ethiopia? What is feasible to achieve given the economic condition of the nation?
20. What do you think should change culturally, economically and politically to improve maternal health outcomes of women in these areas?

APPENDIX B

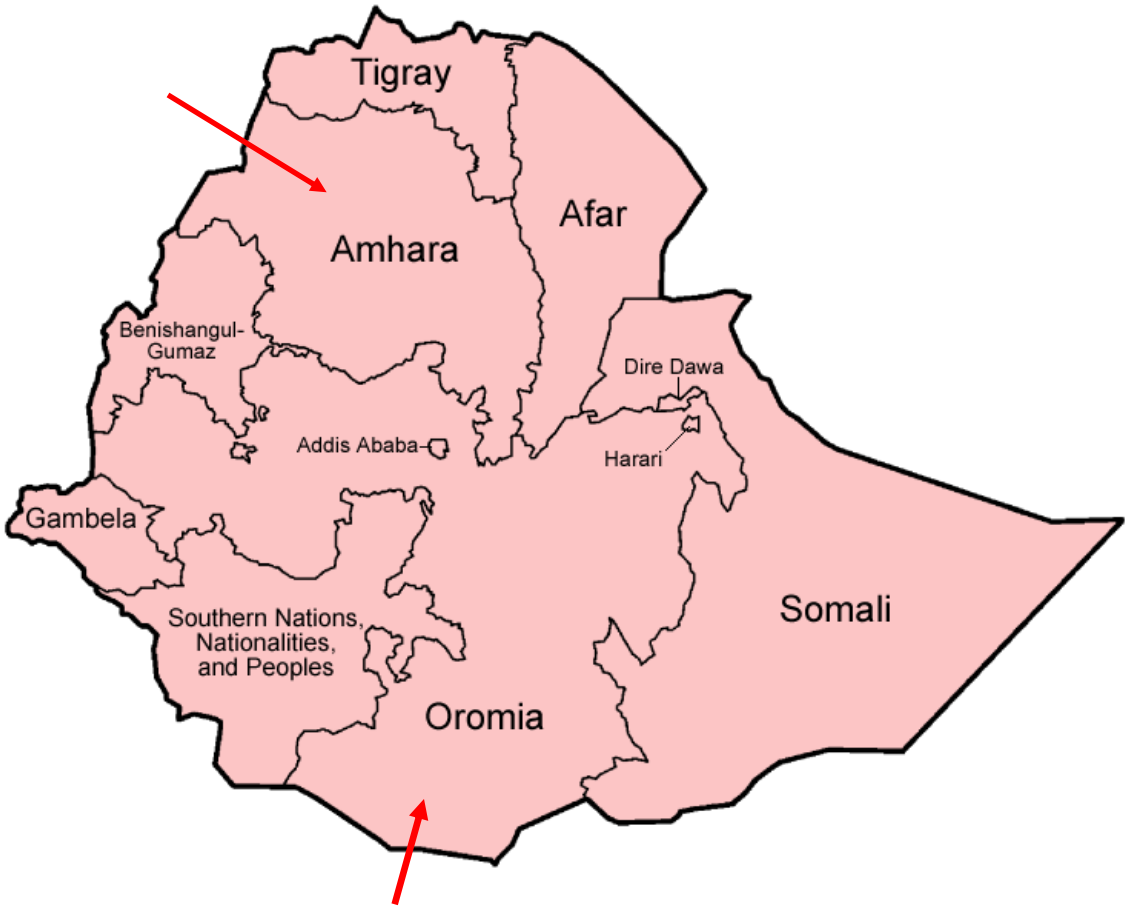
MAPS OF THE REGIONS AND WOREDAS OF ETHIOPIA

REGIONAL AND WOREDA MAPS OF ETHIOPA

Source: UNAIDS

© UNAIDS. 2000. Map of regions and zones in Ethiopia as of April 2000. All boundaries are approximate and not official

AMHARA AND ORMOIA REGIONS

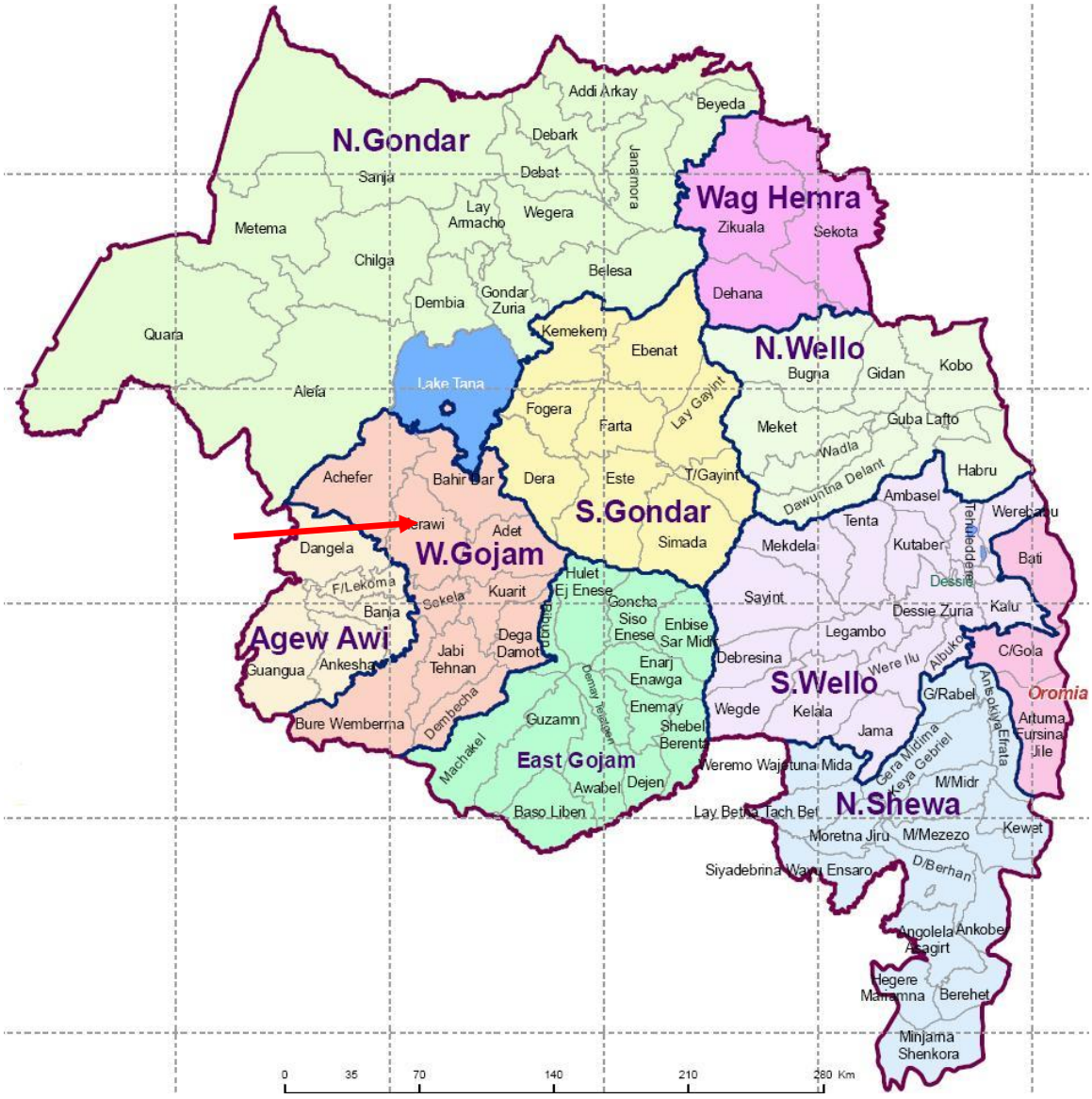


Source: List of Ethnic groups in Ethiopia. Retrieved from: Revolvy https://www.revolvy.com/main/index.php?s=List%20of%20ethnic%20groups%20in%20Ethiopia

SEDEN SODO (KOKIR) WOREDA IN SOUTH WEST SHEWA OF OROMIA

Source: Ethiopian Demography and Health: Oromiya
http://www.ethiodemographyandhealth.org/Oromia.html

MECHA WOREDA IN WEST GOJAM ZONE OF AMHARA



Source: Ethiopian Demography and Health: Amhara
http://www.ethiodemographyandhealth.org/Oromia.html

APPENDIX C

INTERNAL REVIEW BOARD (IRB) APPROVAL

INTERNAL REVIEW BORAD APPROVAL

APPROVAL: EXPEDITED REVIEW

Ann Koblitz
Social Transformation,
School of 480/965-8483
koblitz@asu.edu

Dear Ann Koblitz:

On 4/7/2015 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Maternal Health in Ethiopia: Global and Local Complexities
Investigator:	Ann Koblitz
IRB ID:	STUDY00002449
Category of review:	(6) Voice, video, digital, or image recordings, (7)(b) Social science methods, (7)(a) Behavioral research
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Maternal Health IRB Protocol.docx, Category: IRB Protocol; • Parent's consent form Amharic.pdf, Category: Translations; • Key Informant Interview Amharic version (1).pdf, Category: Translations; • Oral Infromed Consent Guide.pdf, Category: Consent Form; • Focus Group discussion consent form Amharic.pdf, Category: Translations; • Focus Group Discussion Guides.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Aduts consent forms Amharic.pdf, Category: Translations; • Individual Interview Questions Men.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Ora consent form Amharic.pdf, Category:

	Translations; • Key Informant Interview Questions.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Minors consent forms Amharic version.pdf, Category: Translations; • Traslation Certificate.pdf, Category: Translations; • Individual Interview Questions Women.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Parent or Guardian Consent Form.pdf, Category: Consent Form; • Focus Groud discussion guide Amharic version.pdf, Category: Translations; • Interview women Amharic version.pdf, Category: Translations; • Focus Group Discussion Consent Form.pdf, Category: Consent Form; • Minor Assent Form.pdf, Category: Consent Form; • Adult Consent Form.pdf, Category: Consent Form; • Men's interview guide Amharic version.pdf, Category: Translations; •

The IRB approved the protocol from 4/7/2015 to 4/6/2016 inclusive. Three weeks before 4/6/2016 you are to submit a completed Continuing Review application and required attachments to request continuing approval or closure.

If continuing review approval is not granted before the expiration date of 4/6/2016 approval of this protocol expires on that date. When consent is appropriate, you must use final, watermarked versions available under the "Documents" tab in ERA-IRB.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Yamrot Girma Teshome

Yamrot Girma Teshome