Towards Indigenous National Policies and Programs: Maternal Health in Ethiopia

BY

AISSETU BARRY IBRAHIMA
B.A. in Sociology and Social Administration, Addis Ababa University, 2004
M.S.W., Addis Ababa University, 2006

DISSERTATION

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Defense Committee:

Mark Mattaini, Social Work, Chair and Advisor
James Gleeson
Cassandra McKay- Jackson
Brian Kelly, Loyola University
Sekile Nzinga-Johnson, The Health and Medicine Policy Research Group in Chicago

This dissertation is dedicated to my mothers, W/ro Senait Shiferaw and W/ro Aselefech Lakew, who embodied the grit and grace of ‘motherhood’.

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LIST OF ABBREVIATIONS

AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBRHA	community based reproductive health agents
CIA	Central Intelligence Agency
CSA	Central Statistical Agency
DHS	Demographic Health Survey
GDP	Gross Domestic Product
GER	Gross Enrollement Ratio
GTP	Growth and Transformation Plan
HEWs	Health Extension Workers
HSDP	Health Sector Development Plan
IMF	International Monetary Fund
KAP	knowledge, attitudes and practices
MDG	Millennium Development Goals
MMRT	maternal mortality rate
MOE	Ministrty of Education
MOH	Ministry of Health

NGOs	Non Governement Organizations
OAU	Organization of African Unity
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
RH	reproductive health
SAP	Structural Adjustment Programs
SDG	Sustainable Development Goals
SNNPR	Southern Nations Nationalities and People Region
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Emergency Fund
WB	World B

SUMMARY

Maternal mortality is a great challenge disproportionately affecting developing countries. To address this problem, the United Nations (UN) designed international policies including Millennium Development Goals (MDGs) and required developing countries, to adopt these policies in order to access loans or grants. However, these policies failed to bring sustainable change. They are also criticized for being expert-led and embedded in the neo-liberal agenda. This study examines the interface between maternal health policies and their implementation at the grassroots in Ethiopia; and evoke recommendations to address the needs of communities, using indigenous qualitative research methods. The use of indigenous methods decolonizes the study and explore the impact of the 3Cs - colonialism, capitalism, and Christianity (Anderson, 2007) on maternal health policies.

The primary research questions were: 1) How do mothers define their needs? 2) To what extent have their needs been met? 3) What interventions have helped the most? 4) If any gaps remain, what do mothers think would improve their situation? Data was collected using in-depth interviews, visual dialogue with 27 women. Miles, Huberman, and Saldana's (2013) interactive model was used to shape the analysis process. And, ATLAS ti (Version 7.5.11) was used to manage, sort and code the data. Member checks was conducted to verify the analysis, decrease the chances of misrepresentation, and increase local validity.

Research participants identified access to basic needs, basic infrastructure, economic/financial support, education and reproductive health as maternal health needs. They also indicate the gap in facility based services due to lack of cultural considerations. The majority of health professionals being men created a disconnect. The other important finding was the perception of birth as a natural phenomenon and death [maternal mortality] as destined by

God/Allah. Participants also confirmed that the community support for mothers outweigh the facility based support since community members accompany mothers throughout the rituals of the birthing process.

Research participants believe that ensuring economic independence for mothers will improving their wellbeing and health. They also raise importance of equipping traditional birth attendants and allowing them to assist homebirth. To enhance facility-based birth, is necessary to create culturally competent space and services.

I. INTRODUCTION

A. Description of the Study

Since the Millennium Summit in 2000, improving maternal health has been incorporated as part of the Millennium Development Goals [MDGs]. This goal has been adopted by countries in Sub-Saharan Africa as part of their national health policy. Various scholars (Berhane, Gossaye, Emmelin, & Hogberg, 2001; Karim, Betemariam, Yalew, Alemu, Mary Carnell, et al, 2010; Okojie, 1994; Woldemicael & Tenkorang, 2010), have identified the practice of homebirth without a professional assistance, lack of women's autonomy, and inaccessibility of health facilities as major challenges to address maternal health problems pertinent to this region. Accordingly, large sum of investments has been allocated towards achieving this goal through promoting birth at health care facilities and availing emergency obstetrics care. However, maternal mortality continues to be one of the biggest challenges in this region, including Ethiopia.

The World Health Organization defined maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes" (WHO, 2003). The Ethiopian Ministry of Health Report (2010) indicated that the maternal mortality rate in the country has declined from 673/100,000 (DHS, 2005) to 590/100,000. In the current health sector development plan (2010/11 -2014/15) the Ethiopian Ministry of Health intends to decrease maternal mortality ratio by 2/3, i.e. from 590/100,000 live births to 267/100,000; which is still among the highest in the world.

International Finance Institutions such as the International Monetary Fund (IMF) and the World Bank (WB) have significant influence in shaping policies all over the world, especially in

the ‘developing’ countries. The Poverty Reduction Strategies, Growth and Transformation Plans, Millennium Development Goals (MDGs), and now Sustainable Development Goals (SDGs) are themes that are found in national policy documents of many developing countries, including Ethiopia. In most cases these financial institutions have required countries to adopt these policies in order to access loans and grants (Tafesse, 2004).

Sustainable Development Goals (SDGs), which is unanimously endorsed by 193 member states, on September 25th, 2015, is the new global agendas that aims to end world poverty by 2030, fight inequality and protect the environment. Serving as a successor of MDGs that ended in 2015, SDGs has 17 overarching goals accompanied by 169 targets. These goals and targets are enclosed in the United Nations Resolution A/RES/70/1 of September 25, 2015: paragraph 54. Similarly, MDGs promised to address extreme poverty and its manifestation in a comprehensive manner and with a focused framework by 2015 (Morgan, 2005; Migiro, 2007, Miciro, 2007).

Ethiopia has aligned its national policies with international policies. The first national five-year plan, which is known as the Growth and Transformation Plan I (GTP I– 2010/11—2014/15) has aligned its specific objectives, and indicators with the MDGs. The National Health Sector Development Plan (HSDP IV-2010/11-2014/15) of Ethiopia also aligned its objectives to the health related objectives of the MDGs, which are MDG 4: reduce child mortality, MDG5: enhance maternal health, and MDG6: combat HIV/AIDS, malaria and other diseases. According to the Ministry of Health (MoH) document, the Maternal health target in this development plan is to reduce maternal mortality rate from 676/100,000 live births (2010) to 267/100,000 live births and achieve universal access to reproductive health, which encompass easy access contraception by 2015.

Ethiopia also endorsed SDGs. UNDP reports indicate that the country is currently mainstreaming SDGs into national priorities and strategies (July 30, 2015). Confirming the progress of Ethiopia in mainstreaming SDGs, UNDP (April 26, 2016) revealed that "The National Planning Commission is undertaking an exercise to build on Ethiopia's current five-year development plan to develop a 15-year perspective plan (2016-2030) to allow the country fully alignment with SDGs". UNDP has also pledged to support the undergoing formulation process. In addition, numerous national and international organizations started to work in collaboration with the UN and their respective national governments to achieve these goals.

International Policies are often based on Western philosophies. Western oriented policies and intervention approaches tend to be more focused on individuals, ignoring the cultural, communal, and spiritual values that have historically been central to Indigenous communities (Midgley, 2008). Traditional Africans have collectivist cultures. Collectivism as a cultural pattern emphasizes the extended family, community, caste, tribes, and country (Haj-Yahia & Sadan, 2008). Typically, members of collectivist societies have a sense of obligation to their collective community. Their personal satisfaction, self-actualization, and fulfillment is defined in reference to their community; accordingly, they are able to maintain harmony with their collective (Haj-Yahia & Sadan, 2008). Despite this reality, International policies are being adopted in African counties. These policies rarely reflect or mainstream the cultural values of most African countries. In additions, these policies enforce various restrictive requirements in terms of program planning, budget allocation and implementation. Therefore, they fail to address structural problems that are specific to non-Western countries (Chogugudza, 2004).

This research is focused on the implementation of MDG5 that targeted to enhance maternal health and reduce maternal mortality by two-thirds between the years 1990 and 2015, in

Ethiopia. In this country, maternal health programs are implemented and measured in terms of numerical targets and indicators that are in line with MDG. However, maternal health is a human rights and social justice issue, which requires more than minimizing maternal mortality rate. Therefore, maternal health programs and policies should be broad enough to address women's rights, gender based violence, and harmful traditional practices. These issues may not be recognized in a Western context. Thus, to instigate positive change in maternal health in Ethiopia, contextual and culturally relevant policies and interventions that go beyond MDGs are needed. Having culturally relevant policies and intervention are also more likely to improve performance on numerical targets and indicators.

This study examines the interface between maternal health policies and their implementation at the grassroots; and evoke workable strategies and recommendations that might be used to establish Indigenous, i.e. culturally competent, maternal health policies and programs that address the specific needs of communities, using indigenous qualitative approaches. To have relevant social and economic policies in Ethiopia, the starting point must be the community – the target population. This requires decolonizing the process of policy formulation and intervention program planning (McCleland, 2011; Thiong'o, 1994; Tuhiwai Smith, 2012). It also involves developing local, empirically-based knowledge about culturally appropriate solutions to particular contexts (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). Indigenous policy and programs privilege culture-specific knowledge and practice. Indigenous approaches are concerned with developing local, empirically based knowledge about culturally appropriate solutions for particular contexts (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). Indigenous approaches also recognize the presence of cultural diversity, and the importance of developing culturally relevant practice approaches. Indigenous approaches also

challenge the 'internationalization' and 'standardization' of theories, concepts, methods, and standards of education (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). Hence, using indigenous methods is one way to acknowledge and to begin to reverse the damage of the 3Cs – colonialism, capitalism "civilization", and Christianity (Anderson, 2007) on Indigenous communities.

Gray and Coats (2010) argue that indigenization is a naturally occurring process characterized by assimilation and resistance. "It can also be understood as a process of decentering colonial discourse and power structures through tactics that can be resistant or more confrontational (p. 623)." In this process, policy makers are required to recognize their privilege, validate Indigenous wisdom, and discard their power as professionals and scholars (Briskman, 2008). It is empowering for people to articulate their problems and contribute their opinions in solving their problems, since they are experts in dimensions of their issues and their socio-cultural and economic context that others do not recognize.

Given this context, the purpose of this study is to learn about maternal health in Ethiopia from the mothers who are intended to benefit from maternal health policies and programs. The study seeks to answer the following questions using qualitative research methods that is informed by structural social work theory and indigenous research approaches: 1) How do mothers who are intended to benefit from maternal health policies and programs define their needs? 2) To what extent have their needs been met by maternal health policies and programs, community resources and traditional practices? 3) What interventions have helped the most? 4) What gaps, if any, remain in interventions: what do mothers think would improve their situation? Based on the results of the data gathered and research participants' recommendation, the study

informs an alternative culturally-competent maternal health program that considers the grassroots reality.

B. Ethiopia: Brief Introduction

The Federal Democratic Republic of Ethiopia, my country of origin, is an ancient country with a rich diversity of peoples, cultures, a unique alphabet —the Ge'ez script also known as *Ethiopic,* and its own calendar that existed more than 3000 years, which is about seven years behind the Western Gregorian calendar (Page, 2001). Various historical accounts (Ayittey, 1994; Geda & Berhanu, 1960, Gleditsch, 2004) revailed that Ethiopia is one of the few African nations that maintained independence during the colonial era, although it is not immune to the new [neo]colonialism rooted in Western capitalism. The country is also one of the founding members of the United Nations, and the African Union (AU- 2002), the then, Organization of African Unity (OAU) established in 1963. The capital city, Addis Ababa, continues to serve as a seat of AU, and many international organizations. Religion and spirituality also play significant roles in individual and communal life.

Geographically, Ethiopia is found in the Horn of Africa adjoined by Somalia and Djibouti to the East, South Sudan and Sudan to the West, Eritrea to the North, and Kenya to the South. Ethiopia covers 1,104,300 square kilometers, which makes the country the tenth largest country in Africa. The country also has a huge geographical diversity that ranges from mountains as high as 4,550m above sea level to a depression of 110m below sea level.

The current (2015) population projection of Ethiopia is 99,390,750 (50.1% female) (WB data). According to the CSA (2013) the population age pyramid is predominantly young: 44% under 15 years, 52% between 15 to 65 years, and 3% over 65 years. According to the CIA world fact book (2013), the life expectancy is 60 years (57.73 years for male, and 62.35 years for

female). According to the 2007 census, the majority of the Ethiopian population (83.6%) is based in rural areas. The national average household size is 4.7 persons. Addis Ababa, is the largest city in the country, as well as the capital city, with the population size of 2.7 million.

Women in the reproductive ages constitute 24% of the population. The demographic health survey (DHS) (2005) shows that the average lifetime fertility declined in the past 15 years from 6.4 births per woman (1990) to 5.4 births. The total fertility rate (TFR) for urban areas being 2.4, while in rural areas, it is 6.0. Hence, according to the MoH, the average birth is three times more for rural women, compared to women in urban areas

Ethiopia is a multi-ethnic federal state with more than eighty languages spoken. The Federation is composed of nine regional states (killil): Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations Nationalities and People Region (SNNPR), Gambella and Harari Regional States; and two Chartered Cities—Addis Ababa and Dire Dawa. The national regional states and the two city administrative councils are further divided into 817*woredas* (districts) and around 16,253 *kebeles* (smallest local administrative unit) (Ministry of Foreign Affairs, 2010).

About 83.4% of the Ethiopian labor force is engaged in the agricultural sector that yields nearly 43% of the Gross Domestic Product (GDP), and 80% of exports (Ministry of Foreign Affairs, 2010). The Government also adopted a market-based agriculturally led industrialization policy, which is part of World Bank and IMF's poverty reduction strategy —Plan for Accelerated and Sustained Development to End Poverty (PASDEP). Thus, since the past decade, there are a number of initiatives and measures, including privatization of state enterprises and the rationalization of government regulations, to keep this policy going.

Epidemiological and health service research in Ethiopia associates illiteracy with high health risks and low health-seeking behavior. According to the Ministry of Education (MOE, 2010) report, "the gross enrollment ratio (GER) in primary schools rose from 32% in 1990/91 to over 91% in 2006/07, with a male to female proportion of 55.9% and 44.1%, respectively." In addition, "the overall enrollment in the higher education institutions also increased significantly from 138,199 to 304,371, resulting in a higher education GER of 4.6% in 2008/09." However, the overall adulty literacy rate for individuals who are 15 years old and above, who can read and write is only 36% (out of the 36%, 62% for male and 39% for female (MoE, 2010).

The Government of Ethiopia developed the first national health policy 1996/97. These policy is consequently followed by four consecutive phases of comprehensive Health Sector Development Plans (HSDPs). The National Health Policy and HSDPs were focused on "democratization and decentralization of the health care system; developing preventive, promotive and curative components of health care; assurance of accessibility of health care for all parts of the population; and encouraging private and NGO participation in the health sector" (Ministry of Health, HSDP 2010/11 – 2014/15, 2010, P. 4). The Ministry of Health has also introduced different strategic documnents and action plans to improve maternal and neonatal health. Some examples of these documents include: Making Pregnancy Safer (2000), Abortion Law (revised in 2005), Reproductive Health Strategy (2006), Adolescent and Youth Reproductive Health Strategy (2006). In addition, the Ministry trained and deployed female Health Extension Workers (HEWs) to institutionalize community based health care and enhance facility based delivery at Health Post (HP) level. Health Officers (HOs) were also trained in Integrated Emergency Obstetric and Surgery (IEOS) and deployed, giving priority to maternal health.

C. Background, Rationale, and Significance of the Study

Various studies evaluating the effectiveness of maternal health programs in Sub-Saharan Africa by analyzing hospital records, showed its positive contributions in reducing maternal mortality and morbidity (Otchere & Kayo, 2007). On the other hand, other studies that were not specific to hospital records confirmed that many Sub-Saharan African countries, including Ethiopia, revealed that the average risk of dying from pregnancy related causes in Africa is about 1 in 20 (Ujah, et al, 2005; Otchere & Kayo, 2007). The Africa Union evaluation report (2012) indicates that

> Two in three Africans have no access to essential services such as family planning, maternal health care, and HIV prevention and treatment. As a result, about 700 African women die each day from complications of pregnancy and childbirth. Maternal death ratios in Africa are estimated to be between 500 and 1500 deaths per 100,000 live births, compared to 5 to 10 in developed countries.

Moreover, reports from the U.N. and W.B. on the progress of countries towards meeting MDGs reveal that ‘‘Africa is the only continent not on track to meet any of the goals of the Millennium Declaration by 2015 (UN World Summit Declaration, 2005).”

In 2005, the maternal mortality rate in Ethiopian was estimated to be 673 per 100,000 live births (EDHS, 2005). In the Health Sector Development Plan, the government plans to reduce this rate by two-third, i.e. 267 by 2015. However, given the level of poverty in the country, this goal proved to be ambitious, and Ethiopia failed to meet the target. The World Bank database estimated maternal mortality rate (MMRT) in 2015 to be 353. It is challenging to bring significant changes in maternal health working within the current infrastructure, especially in rural areas, where there is a huge gap in basic transportation and communication infrastructures. The roads are only accessible during dry seasons in four-wheel drive cars or motorcycles, and there is no or limited access to electricity, telephone, and internet services. The number of schools and health centers with enough health educators, doctors and other health professionals

is also very limited. Building all the basic structures require time and substantial resources—financial, political and technical. Moreover, the low level of public awareness and consciousness about maternal health issues in the country made the realization of these goals within the targeted time frame, 2015, unrealistic.

International policies such as: MDGs, and now SDGs, which are endorsed by all UN member states – [189, MDGs and 193, SDGs] have a legitimacy and consensus among development actors, including policy makers (at the national and international level), multilateral and bilateral institutions, and other stakeholders. Before the endorsement of SDGs (Sept. 2015), MDGs have been guiding global development policies and programs (2000 – 2015). MDGs have strengthened the good intentions framed in the Millennium Declaration providing a focus for advocacy; reinforced solidarity and purpose galvanizing the international community improving the targeting and flow of aid. Moreover, MDGs [SDGs as well] reinforced the objectives providing templates of targets and indicators thereby improving the monitoring of development projects (Lancet, 2010; Saith, 2007). They have even influenced the complex and ambiguous concept of 'development' to take a very narrow and technocratic path, explained in terms of reducing poverty and meeting the 'goals' (Sumner & Tiwari, 2009). On the flip side, it is argued that "MDGs lack attention to any theory, structural relationships, policies, pathologies or causation linking policy and outcomes and thus by default are embedded in the 'grand neo-liberal strategic agenda' (Sumner & Tiwari, 2009, p, 51)." The MDG are also critiqued for not addressing the power relations that might be respossible for causing the unspeakable poverty in developed, as well as developing nations; while emphazising on mobilization of financial resources and technical support is the (UN, 2008, HR/PUB/08/3). Easterly (2007) also argues that MDGs are are ambitious, which are only meant to motivate extra effort from developing

countries towards achieving them. Achiving MDGs required a large sum of money that developing countries do not have and/or could not raise in any form of grant or loan.

As discussed above, many developing countries, including Ethiopia, have recognized the international plans, and included them in their national policy and national plan of action. Maternal health, which is the focus of this study, was part of MDG5: improve maternal health. Several declarations and plans of action were approved by different countries so as to augment the efforts and commitments of various stakeholders in meeting these goals. Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa known as The Maputo plan of action (2007-2010) can be mentioned as one of the early declarations signed by different countries. This plan of action is adopted by the African Union to achieve the MDGs in the continent. The plan aims to change how governments address reproductive health in their policies, as well as health system strengthening, increasing the availability of sexual and reproductive health supplies, and building of long-term infrastructure. However, this plan of action failed to bring the intended changes in maternal health, especially in sub-Saharan Africa leaving a huge concern that many African countries may not attain MDG 5. Then, the African Union Commission (AUC) and United Nations Population Fund-UNFPA initiated CARMMA (Campaign on Accelerated Reduction of Maternal Mortality in Africa) to intensify the implementation of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. Along with other African countries, Ethiopia has been part of CARMMA. Numerous national and international organizations have also designed different intervention programs and started working in collaboration with the UN, and the national government towards achieving these goals. However, the country still failed to meet the desired goal in reducing maternal mortality rate by 75%.

Despite the presence of several plans of action, initiatives, campaigns and programs that are intended to facilitate the implementation of maternal health policies, many African countries, including Ethiopia failed to meet the maternal health goals that were set in MDGs by 2015. Therefore, it is important to know if the international and national maternal health policies are relevant, understand the gaps between the policies and implementation strategies and the reality at grassroots. It is also important to know if there are barriers in implementing these policies and strategies at the grassroots and learn how these barriers could be bridged in culturally relevant and sustainable ways.

For countries like Ethiopia, ending the Millennium Development Goals (MDGs) and beginning Sustainable Development Goals (SDGs, 2015 – 2030), it is time to figure out why the investments of human, technical and financial resources to enhance maternal health are not meeting their intended objectives. It is also the time to consider how the development programs could continue nurturing the progress towards the intended outcomes. This reflection is also beneficial for 'developed countries', since they have invested billions of dollars to implement different programs intended to eradicate extreme poverty from the world and improve people's life in developing countries.

National policies need to address structural issues due to the socio-cultural and economic realities of citizens. Therefore, it is important to pay attention to cultural diversity, social structures and patterns of communication. Ethiopia is a culturally diverse country, with more than 80 languages and 200 dialects. Religion and spirituality also play significant roles in individuals' and communal life. Therefore, it is important to involve and learn from the target community, using Indigenous approaches to understand the cultural nuances and engage

participants fully. Indigenous approaches provide the opportunity to engage participants in a powerful and meaningful way (Fitzgerald, 2005).

This study challenges the top-down approach in policy development and program design. It allows us to learn from the people about their actual needs and their proposed mechanisms to meet their needs. This process requires going back to one's roots to seek direction, moving away from adopting Western theories and practice approaches (Gray & Coats, 2010; Thiong'o, 1994). Indigenous methodologies acknowledge that there is no standard policy and/or intervention program, which can be replicated everywhere and yield similar results. Hence, secular approaches that ignore these facts will not effectively address the social problems.

D. Theoretical and Conceptual Considerations

Dealing with maternal health issues in Africa requires consideration of structural issues, which are related to human rights, good governance and poverty. Therefore, I used structural social work theory (Mullaly, 2007) as a framework for analyzing international and national policies and strategies, as well as assessing the gap between these policies and grassroots interventions. I also used Indigenous approaches (Tuhiwai Smith, 2012) to guide my methodology and data analysis so as to capture the knowledge, attitude and experiences of people in the study to contribute to formulating culturally consonant maternal health policy and programs that participate in and consider the grassroots reality.

1. Structural Social Work and Indigenous Methodologies

Structural social work has evolved from helping people to modify situations that limit their functioning (Middleman & Goldberg, 1974), to dealing with discrimination through advocacy within the given political and organizational arena (Davis 1991, cited in Mullaly, 2007), then to changing of existing structures that perpetuate inequality (Mullaly, 2007).

Structural social work highlights social justice as a core principle. Social justice entails fair distribution of goods and resources, and confronting any social conditions, process, or practice that hinders one from fully participating in society (Mullaly, 2007).

In any reseach, methodology is important as it frames the questions, determines the set of instruments to be used, and shapes the analysis (Tuhiwai-Smith, 2012). Denzin and Lincoln (2008) defined Indigenous methodologies as "research by and for Indigenous people, using techniques and methods drawn from the traditions and knowledge of those peoples" (p. x). In Indigenous research, "questions are framed differently, priorities are ranked differently, problems are identified differently, and people participate on different terms" (Tuhiwai-Smith, 2012, p. 196). Indigenous research protocols require building relationships and collaborations between the researcher and research participants so as to forge trust, equity and partnership in the whole process. This research paradigm is appropriate to the needs of Indigenous communities in their struggle for self-determination as it can emancipate social change (Kovach, 2010).

Alike structural social work, Indigenous research also challenges the so called objective, value-free, and scientific process for observing and analyzing human reality, due to the emphasis placed on deterministic models of analysis and its denial of culture as a mediating force (Tuhiwai-Smith, 2012). This research acknowledges that developing Indigenous approaches requires a balance, challenging dominant models of practice and research, while integrating traditional values and practices that have withstood centuries of oppression into culturally consonant forms of service and inquiry. In this manner, indigenous approaches can serve as framework that brings policies, interventions, and grassroots efforts together.

In this research, I used indigenous methodologies and structural social work theory to shape my methodology and analysis, since both of them value people's perspectives, their

cultures, norms and traditions. The use of indigenous approaches gave me the flexibility of using my 'self' as a research tool. Sharing my personal experience as a woman and a mother, has played a significant role to build rapport and equitable relationship with my research participants. These personal reflections and conversations are documented and reported in the finding chapter. In addition, the narratives on motherhood and its characteristics emerged from my conversations with research participants. During the interviews, research participants defined motherhood and discussed the rituals around birthing before they talked about maternal health needs. Therefore, even if it is not included in the primary research questions, "motherhood" and the rituals around birth became the major part of this study.

2. Research Approaches

This study used qualitative research methods informed by Indigenous research approaches (Tuhiwai-Smith, 2012). Indigenous methodologies recognize the culture, languages, and the struggle of people for social justice to become self-determining. Indigenous approaches also allow different ways of knowing, thereby challenging positivist epistemology (Tuhiwai-Smith, 2012). Data was collected using in-depth, semi-structured interviews and observation. Interviews were conducted with 27 women (18 years old and above) living in *North Wollo Zone* in Northern Ethiopia who are targeted to benefit from maternal health policies and programs. This *Zone* has 8 *Woredas*, with a population of 1,500,303.

E. Theoretical Sensitivity

I am passionate about this topic because I worked with a community based non-governmental organization as an HIV/AIDS/ RH program advisor. One of the programs I was leading was a safe motherhood promotion program that incorporates prevention and support programs for women and girls suffering from Fistula problems. Fistula is a complication that is

caused by prolonged labor (Muleta, 2006). Fistula can also be prevented by providing emergency obstetric care to women experiencing obstructed labor. However, in many developing countries, where adequate medical care may not be available or affordable, women may never get corrective surgery because they cannot afford medical support, or cannot travel to a hospital that is located somewhere in the city, way far from where they are. Early marriage is one of the major causes that expose girls to Fistula complications since they are forced into marriage and childbearing before their body is strong enough to carry a child (Muleta, 2006; Thomson, 2007). As child marriage (from 9-14 years old) is commonly practiced in *North Wollo*, I have seen girls suffering from this medical complication, as well as subsequent rejection by their husbands and their community. Thus fistula becomes a psychological, social and emotional problem, in addition to being a medical 'case'.

Working in 'Safe Motherhood' programs, I know that there is international as well as national commitment to curb the problem of maternal health. However, the material, human and financial resources that are invested in maternal health interventions do not seem to reduce maternal mortality or enhance maternal health at the intended rate. I have also observed a glimpse of hope that tangible and lasting change in promoting health can be achieved if the community is involved and if interventions consider the significance of cultural and spiritual contexts. Working in partnership with religious institutions and community associations resulted in reduction in early marriage and other harmful practices such as forced marriage, abduction, and female genital mutilation in many parts of Ethiopia.

Therefore, I want to know why the national and international investments to enhance maternal health and reduce maternal mortality rate are not working as planned, and I want to contribute to curbing this problem. As Denzin and Lincoln (2008) argued indigenous research is

"research by and for Indigenous people, using techniques and methods drawn from the traditions and knowledge of those peoples" (p. x). Having a personal connection and work experience in these communities, it is a great opportunity for me to be in *North Wollo* to learn about the issues related to maternal health, and providing women, who are often 'targets' of policies, a space to get their voice heard.

Given my background in this area, I have taken several measures to reduce potential researcher bias and ensure trustworthiness of findings (detailed in the methodology chapter): variation sampling; using a second coder; conducing a member check; using thick description; memoing; and frequent consultation with the chair of my dissertation committee.

F. Research Questions

This study seeks to answer the following questions:

1. What supports does a mother need? In other words, how do the mothers, who are intended to benefit from maternal health policies and programs, define their needs? [program based needs, community resource needs, spiritual needs, and needs based on traditional practices]
2. To what extent have their needs been met? [By maternal health policies and programs, by community resources and traditional practices?]
3. What has helped the most?
4. What if any gaps remain; what do mothers think would improve their situation?

II. LITERATURE REVIEW

A. Introduction

On September 25, 2015 193 UN member states unanimously endorsed a new global agenda: Sustainable Development Goals (SDGs), promising to end world poverty by 2030, fight inequality and protect the environment. SDGs has 17 overarching goals with 169 sub-targets, which are enclosed in the United Nations Resolution A/RES/70/1 of September 25, 2015: paragraph 54.

Figure 1: Sustainable Development Goals (SDGs), UNDP, retrieved August 7, 2016

SDGs are the successor of MDGs, which was an eight-point plan with 21 sub-targets. While discussing the epoch after MDGs, Sumner (2009) recommended assessing: the impact of the MDG approach on poverty reduction; the meta-processes that could shape development over the next 10 -15 years, and what should replace the MDG approach. Giffen & Pratt (2011) also came up with three alternatives as post-2015 frameworks: Option 1: more of the same, but with refinements and specific focus: i.e. continuing with the same MDGs with or without a timeline (Sumner, 2009); option 2: developing broader, context specific goals that encompass human

rights and other cross-cutting issues; and option 3: come up with brand new approaches or alternative paradigm. Examining SDGs, it looks like the UN took option 2 of Giffen & Pratt (2011). SDGs included a longer list of goals and targets that include cross-cutting issues such as human rights, good governance and climate change. Maternal health that is the major focus of this study was one of the eight major goals in MDGs, addressed under MDG 5: enhance maternal health through reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 (United Nations, 2010), and universal access to contraceptive by 2015. In the current SDG, addressing maternal mortality is under the overarching goal 3: ensure healthy lives and promote well-being for all at all ages, with a target of reducing global maternal mortality ration to less than 70 per 100,000 live births by 2030.

Despite the presence of international and national policies and goals women still suffer from pregnancy related complications, and various studies indicate that Sub-Saharan Africa has one of the highest MMR in the world, with an estimated rate getting as high as 1 in 20 women (Geelhoed, Lucia, Visser, Asare, Leeuwen, & Roosmalen, 2003; Ujah, et al, 2005).

The Government of Ethiopia targeted to improve maternal health, and reduce the Maternal Mortality Ratio (MMR) by 75% over the period 1990 to 2015; i.e. reducing MMR from 676 [in 2005] to 267 per 100,000 live births [in 2015]. The 2010 Ministry of Health progress report indicated that the MMR was reduced to 590 per100000 (HSDP, 2010). And according to the World Health Statistics 2015 Ethiopia's MMR is 353, which is very different from the target set by the Ethiopian Health Sector Development Program (2010/11) – 267. The World Health Organization's (WHO) World Statistic Report indicates that WHO relies on "government birth and death registration systems, hospital records, household surveys, censuses, certified expenditure records and data obtained from research projects" to compile the World Health

Statistics. WHO also acknowledges that the quality of country based data may vary based on the strength of health information systems in the countries.

For countries like Ethiopia, where only 10% of births are carried out by skilled professionals (EDHS, 2010), it is hard to find adequate hospital data to estimate maternal mortality for the country as a whole. This discrepancy in MMR reported on EDHS (2010) and WHO data is a clear indication of a problem in health data management system. Thus, it is challenging to rely on maternal mortality ratios as indicators of maternal health.

In this chapter, international and national policy documents, theoretical frameworks, and studies that are related to maternal health are reviewed and analyzed. More emphasis is given to MDGs, which shaped international and national development policies and programs from 2000 – 2015. Most of the research included was published after the Millennium Development Goals (MDGs) were introduced in 2000. Yet, a couple of articles date back to 1987, when the first safe motherhood initiative is launched. I have excluded studies that relate maternal health to HIV/AIDS, since HIV/AIDS involve additional policies and intervention frameworks that are not the focus of my research.

Given this context, the evolution of MDGs as a global poverty reduction plan is discussed in this literature review, in line with the key stakeholders that played significant roles in its formulation as well as implementation—the UN, multilateral and bilateral donors, and private donors. In addition, maternal health policies and intervention programs were analyzed in light of international as well as national efforts to enhance maternal health. Since health beliefs, culture, physical environment, and social ties significantly affect health-seeking behavior as well as service utilization within a given community (Chrisman, 1977), studies that assess health-seeking behavior in maternal health are analyzed. Finally, Indigenous knowledge and approaches

are explored and discussed as an alternative approach to further improve maternal health in Ethiopia, bridging policies, interventions and the grassroots.

B. Millennium Development Goals (MDGs): Formulation and Implementation

Hulme (2009) describes MDGs as "the world's biggest promise—a global agreement to reduce poverty and human deprivation at historically unprecedented rates" (p.4). These goals comprise an eight-point plan that addresses extreme poverty and its manifestation in a comprehensive manner and with a focused framework by 2015 (Morgan, 2005; Migiro, 2007, Miciro, 2007). These goals are: "MDG1—eradicate extreme poverty and hunger; MDG 2—achieve universal primary education; MDG3—promote gender equality and empower women; MDG4—reduce child mortality; MDG5—improve maternal health; MDG6—combat HIV/AIDS, malaria and other diseases; MDG7—ensure environmental sustainability; and MDG8—develop a global partnership for development" (http://www.un.org/millenniumgoals).

MDGs were not new creations of the UN in 2000. Antecedents of MDGs can be traced in the *Declaration of Human Rights* of 1948, in the provision: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care…' (UN *Declaration of Human Rights*, Article 25). Reducing poverty and hunger, promoting health, achieving universal primary education and promoting gender equity, which are central parts of MDGs, have always been at the forefront of the United Nations development agenda.

Examining the trends of international policies, the 1960s marked important developments in the UN agenda as it was the year of independence for many countries under colonial rule. The admission of 17 new countries to the UN instigated the issue of development to become a central theme and the decade was declared unanimously in the General Assembly to be the first UN

Development Decade, calling for accelerated measures to eliminate illiteracy, hunger and disease (Jackson, 2007; Hulme, 2009). In the 1980s the third New Development Strategy for the Third United Nations Development Decade was launched. This strategy set poverty reduction goals, objectives and targets to be reached by 1990. Hulme (2009) argues that the influence of the IMF and World Bank increased during this decade as they enforced structural adjustment policies on the growing numbers of poor countries applying for loans. Structural Adjustment Programs (SAPs), are designed to enhance cash flow into a given country through promoting exports, increasing tax, cutting social spending such as health care and education, privatization of the public sector, and removing restrictions on the international capital flow, coming in and out of the country.

Peabody (1996) explained SAPs in terms of three general objectives characterizing the approach of IMF and World Bank as: 1) Reducing aggregate demand, particularly for imported goods, and government expenditures for goods or services, by devaluing currency, and reducing the money supply. This process is believed to reduce domestic consumption, and "increase foreign exchange that can be used for critical purchases of goods and services that will lead to economic growth" (p. 824). 2) "Expanding production, particularly of exported goods, which shifts labor and capital from non-traded to traded goods. The IMF approach pushes for markets rather than governments to set the price and is designed to encourage national economies to use their comparative advantage" (p. 824). 3) Changing government institutions and economic policies, by promoting privatization, deregulation of industries as well as agricultural production, and elimination of subsidies. Also, empowering central banks to control the exchange rate and control inflation by reducing the money supply (p.824).

After comprehensive analysis on the association of policies and development with IMF and World Bank loans, Easterly (2005) clearly indicated that structural adjustment failed to generate the intended growth to participating developing countries. “Structural adjustment loans were repeated many times to the same country, which itself is suggestive of limited effect of the earlier adjustment loans” (p.20). He also criticized the evaluation techniques used to measure success of structural adjustment program—objective based evaluations as well as counterfactual methodology. The objective based evaluations measure program success using imposed benchmarks, against unrealistic donors’ and/or policy making institution’s expectations. The counterfactual methodology is based on what changed after the intervention compared to what would have happened without the intervention.

> … Countries that received adjustment loans did so because they were having poor macroeconomic and growth outcomes, and so it would not be surprising if we found a negative association between these outcomes and adjustment loans without correcting for selection bias. To use a medical analogy, we would expect hospital patients to be sicker than the average person on the street, but this does not imply that hospitals cause sickness (Easterly 2005, p.3).

Therefore, the structural adjustment policies failed to deliver economic growth, education and health (Easterly, 2005; Hulme, 2009; Jackson, 2007), since their conception of growth and economic wellbeing are primarily shaped by Western corporate values and rarely recognize cultural contexts (Rodrik, 1990).

Following the failure of SAP, in the 1990s, the focus of the UN conferences shifted to institutional development including good governance, transparency, accountability, decentralization, and social security. In the International Conference on Population and Development (ICPD), which was held in Cairo in 1994, participants agreed to adopt rights-based approaches to promote sexual and reproductive health, gender equality and women empowerment; achieve universal education; and reduce child and maternal mortality. These

decisions were very important foundations for the formulation of MDGs since they become parts of the MDGs as goal 2 – achieve universal primary education; goal 3 – promote gender equality and empower women; goal 4 – reduce child mortality and goal 5 – improve maternal health. The 2000 Millennium Declaration, therefore, combined the efforts to address poverty, economic and social development in holistic manner, bringing the goals agreed on various UN conferences in the preceding years (Hulme, 2009; Jackson, 2007: Sumner & Tiwari, 2009).

MDGs are endorsed by 189 countries all over the world. This huge constituency ensured the legitimacy of MDGs, and consensus among development actors, including policy makers (at the national and international level), multilateral and bilateral institutions, and other stakeholders. MDGs have strengthened the good intentions framed in the Millennium Declaration providing a focus for advocacy. Saith (2007) argues that MDGs reinforced solidarity and purpose, galvanized the international community, improved the targeting and flow of aid. MDGs also instrumentalized the development objectives by providing templates of targets and indicators, which enhanced the monitoring and evaluation of projects (Lancet, 2010; Saith, 2007). MDGs also influenced the complex and ambiguous concept of 'development' to take a very narrow and technocratic path, explained in terms of reducing poverty and meeting the 'goals' (Sumner & Tiwari, 2009).

However, it is argued that MDGs used classical economic reasoning which have been pushed by the WB and IMF (Nyamu-Musembi & Cornwall, 2004). Thus, they are embedded in the 'grand neo-liberal strategic agenda' (Sumner & Tiwari, 2009). Saith (2006) stress that "… the entire MDG scaffolding and accompanying text is insufficiently global in its approach. It tends to ghettoize the problem of development and locates it firmly in the third world — as if development is fundamentally and exclusively an issue of absolute levels of living" (p. 1184).

Easterly (2007) also argues that MDGs, poorly and arbitrarily designed to evaluate progress out of poverty and deprivation, make Africa look worse than it really is.

> … This more benevolent interpretation, exaggerate the ‘‘Africa as failure” image, which in turn exaggerates the role of ‘‘the West as Savior” for Africa (as the MDG campaign has often played out in practice) … It is demoralizing to have goals for Africa that can only be attained with progress that is nearly without historical precedent from other regions or in Africa itself (p. 33).

C. Progress of MDGs and Prospects of SDGs

Borghi, Ensor, Somanathan, et al. (2006) argued that the current investment in maternal health is insufficient to meet MDG5. Thus, substantial resources are required to strengthen the health system, and enhance the demand and coverage for maternal health service. Currently, various UN based statistics show that “most African countries spend less than half the WHO recommended minimum package of $40 per person on health” (Wakabi, 2010, p. 943). Thus, in addition to the UN agencies, the G8 countries, and other donors, governments of developing countries should allocate increased resources to achieve health MDGs (Starrs & Sankore, 2010). However, governments in poverty stricken countries could not increase resources, hence, failed to meet MDGs. Sahn and Berner (1995) argue that

> In Africa the viability and sustainability of reforms is more difficult and precarious because of several constraints. African countries often have poor ‘enabling environments’ for reforms in several respects: (1) the politicization of economic life and of public administration; (2) poor macroeconomic environments which create fiscal and foreign exchange constraints; and (3) weak public institutions resulting from the absence of state autonomy as well as inadequately trained and motivated civil servants. Not only is the state ‘overextended,’ it is also exhausted (p. 212).

Examining this situation, the need of support/aid to enhance health and development in Africa is not arguable. However, the way aids are channeled is often a point of controversy. In his article published on the Lancet (2010), Tedros Adhanom Ghebreyesus, The Minister of Health for Ethiopia, argues that “country ownership is the surest way for developing counties to

chart their own courses of development and overcome the challenges they face in building effective and productive state" (P. 1127). He also layout four key steps that helps to realize country ownership as: 1) Planning —countries must start with clear development vision and a road map for realizing this vision. Development partners also need to be open and allow countries the space to identify their own needs and priorities. 2) Resourcing the plan—countries need to take the lead and prioritize their needs due to the limited resources. Countries would have a greater leverage in managing resources responsibily if funding is flexible and predictable. 3) Implementation—countries should be fully engaged in implementation. For efficient and sustainable intervention, partners should strengthen existing capacities within the country rather than replacing them with parallel structures; and 4) Monitoring and evaluation —donors should help countries to develop their performance tracking system since mutual accountability [between donor partners and recipient countries] require results-based framework. Sahn and Bernier (1995) stressed that the health sector reforms are more likely to be successful if indigenous non-governmental organizations and communities are involved. Therefore, for successful program implementation donors must incorporate Indigenous actors as partners.

Beginning a new period of global development goals, it is time to rethink 'development'. For donors addressing the multi-dimensional poverty is central. However, their commitment emphasized addressing economic growth and social spending through dictating goals to the 'South' receiving countries (Muchhala & Sengupta, 2014; *The Economist*, March 28, 2015). Also, maternal mortality and child survival were given limited attention (Sumner, 2009). Sumner also asked if the adoption of the MDGs is just a reflection of the donor-recipient relationships between donors and aid-dependent countries or not, wondering if there is a sense of ownership by governments or by civil society.

In the same way, SDGs that replace MDGs in January 2016, are criticized for being over ambitious, extremely expensive – requiring $2 trillion-3 trillion a year over 15 years, and 'cookie cutter' development policies with less significant outcome (*the Economist,* March, 2015). In their commentary on *Economic and Political Weekly* (Nov. 2014), Bhumika Muchhala, and Mitu Sengupta mentioned that SDGs lack a "meaningful language on systemic reforms of global institutions that will address the root causes of poverty (such as debt cancellation for the poorest countries)" and the "myriad green lights given to private sector financing and partnerships for sustainable development, without any specific language on evaluations, accountability, transparency and overall governance, are deeply worrying." Hence, SDGs allow multinational corporations and foundations to take the leading role in development financing and agenda-setting (Muchhala & Sengupta, 2014).

More local ownership of the SDGs may indeed lead to their having a greater impact. International policies and 'development' programs that have been designed and prescribed by 'experts' who may have no or limited knowledge about the target area and the population, do not have sustainable outcomes (Hancock, 1989; Midgley, 2008). Several studies have demonstrated that health intervention programs designed in collaboration with communities tend to be more effective and sustainable, since communities will have a heightened sense of responsibility and consciousness regarding their health, and build a sense of ownership over the initiatives (Botes & Rensburg, 2000; Zakus & Lysack, 1998). However, this idea needs to be explored more.

D. Reflections of MDGs in Ethiopian National Policies

Reducing poverty and safeguarding human development have been part of the Ethiopian Government objectives since the 1990s. This objective is clearly incorporated in different government policy documents. MDGs play a central role in shaping these national government

policies. Ethiopia's midterm national development plans such as: Plan for Accelerated and Sustained Development to End Poverty (PASDEP-2005/06-2009/10) and Growth and Transformation Plan (GTP- 2010/11-2014/15), which is PASDEP's successor, are MDG based. According to UNDP reports (2010), the MDGs Needs Assessment conducted by the government, United Nations Country Team (UNCT) and other partners in 2005, allowed the full integration of MDGs, and the budget required to meet these goals in the national development plan. Moreover, the Ethiopian Ministry of Finance and Economic Development (MoFED) 2010 MDG report indicated, the Government of Ethiopia has allocated the necessary human and physical capital to achieve MDGs.

After endorsing SDGs, the UNDP is working closely with the Ethiopian Government National Planning Commission to mainstream SDGs into national priorities and strategies. (http://www.et.undp.org/content/ethiopia/en/home/presscenter/articles/2015/07/30/getting-familiar-with-the-sdgs.html). UNDP's report also confirm that the National Planning Commission is working to build on Ethiopia's current five-year development plan (GTP II) into a 15-year perspective plan (2016-2030) in order to align it fully with SDGs. And, the UNDP has pledged to support the formulation process. (http://www.et.undp.org/content/ethiopia/en/home/presscenter/articles/2016/04/26/ethiopia-s-national-sdg-consultation-explores-mainstreaming-finance-and-m-e.html).

Summary

SDGs and MDGs have shaped development discourses in national policies and poverty reduction programs. In Ethiopia, they are even used as progress indicators, which are acknowledged in the policy documents as well as program plans. Accordingly, various donors and international organizations are working in collaboration with the national government to

meet the international goals and targets. However, the country is still struggling to provide the minimum required services to women and children.

E. Maternal Health Policies and Intervention Programs

In developing countries, women comprise more than half of the labor force in food production, 70-80 percent of health related care, and bear the principal responsibility in maintaining the home and caring for children and the elderly (Tinker, 1991). Therefore, women make significant contributions to national development. Nonetheless, several studies (Abdella, 2010; Freedman, 2001; Geller, Cox, Callaghan, & Berg, 2006; Luck, 2000; Mahler, 1987; Mbaruku, Vork, Vyagusa, Mwakipiti & Roosmalen, 2003; Potts & Hemmerling, 2006; Tinker, 1991) confirmed that every minute a woman dies from pregnancy or childbirth related complications. This "adds up to half a million deaths every year, with 99 percent of these taking place in the developing world. In addition, countless more women suffer from illnesses caused or aggravated by pregnancy such as anemia and malaria, or sustain permanent disabilities" (Tinker, 1991, p. 18). In this kind of unfortunate situation, the human suffering as well as the financial expenses related to these illnesses and death are enormous (Tinker, 1991).

Compared to any other health indicators, the gap in maternal mortality ratios between developed and developing countries remain wider. "The problem is worst in Africa and South Asia, where risks of childbearing are compounded by women's low social and economic status and high fertility. Indeed, African women have a one in 18 lifetime risk of dying from pregnancy-related causes, compared with a one in 10,000 risk for women in Northern Europe" (Tinker, 1991, p. 18). Woman's quality of life before the pregnancy influences her wellbeing after pregnancy, during birth and after. Chronic deficiencies of calcium, vitamin D, or iron may cause a constricted pelvis, which may lead to prolonged labor and ultimately death during labor

(Syagga, 2011). Chronic anemia may lead to death from hemorrhage (Tinker, 1991). “Risks resulting from adolescent pregnancy, maternal exhaustion due to closely spaced births and heavy physical labor during the reproductive years, procreation after age 35 and especially after age 40, and illegal induced abortion are all factors in high maternal mortality rates in developing countries” (Mahler, 1987, P. 20). Behind every death in pregnancy and childbirth is a personal tragedy more than a biological or medical event (Freedman, 2001). The death of a mother, especially in the developing world, is devastating for her infant as well as older children (Thinker, 1991).

In 1987, the World Bank, the World Health Organization (WHO), and the United Nations Population Fund jointly launched the Safe Motherhood Initiative that brought maternal and child health to the forefront of public health concerns (Mahler, 1987; Potts & Hemmerling, 2006). The goal of this Initiative was to reduce maternal mortality and morbidity by at least half by the year 2000. Since the targets could not be met by 2000, improving maternal health was incorporated in MDGs as MDG 5. This time, the target became reducing maternal mortality by 75 percent by the end of 2015. However, the Safe Motherhood Initiative still failed to reduce maternal mortality significantly especially in Sub-Saharan Africa (Potts & Hemmerling, 2006).

1. Maternal Health as A Human Rights Issue

Mothers are the pillars of society. Child wellbeing begins before birth, with the health status of the girl who becomes a mother. Accordingly, it is crucial for the development of prospective future generations. “When mothers are malnourished, uneducated, and in poor health, their children face a higher risk of either premature death or continuing in the vicious cycle of poverty” (Tinker, 1991, p. 18).

The painful fact that 600,000 maternal deaths (99% of the world) happen in developing countries and nearly all of them being avoidable makes maternal mortality an issue of human rights (Abdella, 2010; Freedman, 2001). Health is "profoundly driven by the social and cultural contexts in which it exists, and that context ranges from the most intimate spaces of daily life to the macroeconomic policies of international financial institutions" (Freedman, 2001, p. 53). Looking at this discrepancy, maternal mortality is not just a 'natural' phenomenon (Freedman, 2001). Yet, it is directly or indirectly caused by discrimination against females in education, nutrition, and other aspects of life (Mahler, 1987).

Human rights are international standards that have been negotiated and accepted by governments as binding upon them and in their countries. These standards can help solidify the grounds of maternal health as a human rights issue, and highlight the relationship between duty-bearer and rights-holder. Assessing some of the internationally accepted standards, maternal health is directly related to the right to an adequate standard of living including special care and assistance in motherhood and childhood (art 25, UDHR -Universal Declaration of Human Rights), the right to the highest attainable standard of health (art 12, ICESCR-*International Covenant on Economic, Social and Cultural Rights*, art 24, CRC-Child Rights Convention) and the right to be free from discrimination in the field of health care so that all women have appropriate services in connection with pregnancy, confinement and the post-natal period (arts 12, 14, CEDAW-*Committee on the Elimination of Discrimination against Women*). Nevertheless, with human dignity as its core value, the whole human rights endeavor is also meant to inspire profound and fundamental change in the most everyday interactions of life.

The United Nation Human Rights Council acknowledged preventable maternal mortality as a human rights violation in its 2009 resolution, proclaiming "most instances of maternal

mortality and morbidity are preventable, and that preventable maternal mortality and morbidity is a health, development and human rights challenge that also requires the effective promotion of human rights of women and girls" (Resolution 11/8 Article 2, 2009).

To truly grapple with the complex of issues that underlies maternal mortality, Freedman (2001) argues that we need to put together the words 'daring' and 'change', and acknowledge their connection.

> It is precisely the role of human rights to identify the workings of power that keep unacceptable things as they are, and to challenge that power with a different vision of human well-being…. It [maternal mortality] will always be daring because it requires us to dare to imagine a different reality, and to have the courage to call, each in his or her own voice and with his or her own means, for the rearrangements of power necessary to change the unacceptable. So we need to begin with the consensus that death in pregnancy and childbirth is unacceptable (p. 53).

2. Maternal Health Interventions and Trends

The Safe Motherhood Conference held by the World Bank, the World Health Organization (WHO), and the United Nations Population Fund in Nairobi, brought maternal health to the forefront of international public health concerns (Mahler, 1987). This initiative targeted reducing maternal mortality by 50 percent by the end of 2000. According to Geller, Cox, Callaghan, & Berg (2006), the goals of this initiative were "to raise international awareness of safe motherhood, develop program priorities, support national programs, stimulate research, mobilize resources, and share information to make pregnancy and childbirth safer" (p. 176). Safe Motherhood ensure every woman high-quality maternal health services, and provide access to reliable economic and social conditions that allow women to be safe and healthy during pregnancy and childbirth (Safe Motherhood, 2002).

In the 1987 Safe Motherhood Initiative, major emphasis was given to strengthening primary health care, which provide women living in remote areas, access to fundamental maternal health services, family planning, and emergency obstetric services (Mahler, 1987). The

WHO family planning policy also recognized family planning as part of maternal and child health care. In addition, socioeconomic development and female litracy were identified as long-term strategies for controlling maternal mortality. Then, Mahler (1987, p. 23) identified four steps as essential strategies: “1) providing adequate health and nutrition services for girls and family planning services for women 2) providing good prenatal nutrition and health care and identifying high risk women early in the pregnancy 3) assuring professional attention for all deliveries, and 4) providing access to obstetrical care for high risk deliveries and obstetrical emergencies”. Some of the existing services and resources used to enahce safebirth can be strengthened through the collaborative efforts between local, and national governemtns as well as international and nongovernemental assistance (Mahler, 1987). However, putting this plan in to action was very challenging.

Maternal health continued to be a huge concern during the Millennium Summit in 2000. Thus, it was incorporated as part of the MDGs as Goal 5: improve maternal health, through reducing maternal mortality and morbidity ratios by 75%, between 1990 and 2015; and providing universal contraceptive coverage. The universally adopted indicators used to monitor and evaluate the achievements of this goal were 1) ratio of maternal mortality; 2) percentage of births attended by skilled health personnel; 3) prevalence rate of contraceptive; 4) rate of adolescent birth; 5) coverage of antenatal care.

The World Health Organization defined maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes” (WHO, 2003).

Ooms, Mulumba, Hammonds, Abdul Latif, Waris, and Forman (2013) indicated that Progress towards MDG5 has been significant; however, it has been too slow to be achieved in 2015, particularly in sub-Saharan Africa unless there is a global social contract for health, that incorporates the international community, which proved to be true. This process would have obliged national governments to obey the right-to-health commitments under the International Covenant on Economic, Social and Cultural Rights; while the international community should be encouraged to increase health aid. Moreover, it was important to enhance the prominence of southern leadership and commitment to improve funding and effective use of resources (Ooms, et al, 2013).

Lozano, et. al, (2011) analyzed the international progress towards achieving MDGs 4 and 5 in 2010 using various surveys, censuses, vital registration, and verbal autopsy data. To assess maternal mortality, they used an ensemble model based on the models with the best out-of-sample predictive validity to generate new estimates from 1990 to 2011. The results of their analysis demonstrate that maternal mortality has declined from 409,100 (uncertainty interval 382,900 – 437,900) in 1990 to 273,500 (256,300 – 291,700) deaths in 2011. However, in developing countries, only 13 countries achieved MDG 5. Despite the progress on reducing maternal mortality, they concluded that most developing countries need many more years after 2015 to attain the goals of MDG 5.

The 2011 UN report on MDGs also affirmed the finding of Lozano, et al (2011). Despite progress, pregnancy remains a major health risk for women in several regions. The UN (2011) prevails that between 1990 and 2008, the maternal mortality ratio dropped by 34% in the developing regions as a whole. However, this drop is far off from the MDG target.

The World Health Organization, UNICEF, United Nations Population Fund and The World Bank data on Trends in Maternal Mortality: 1990 to 2015 also confirms that every region in the world has advanced in reducing maternal mortality rate. However, as the following graph indicates, MMR remains very high in sub-Saharan Africa.

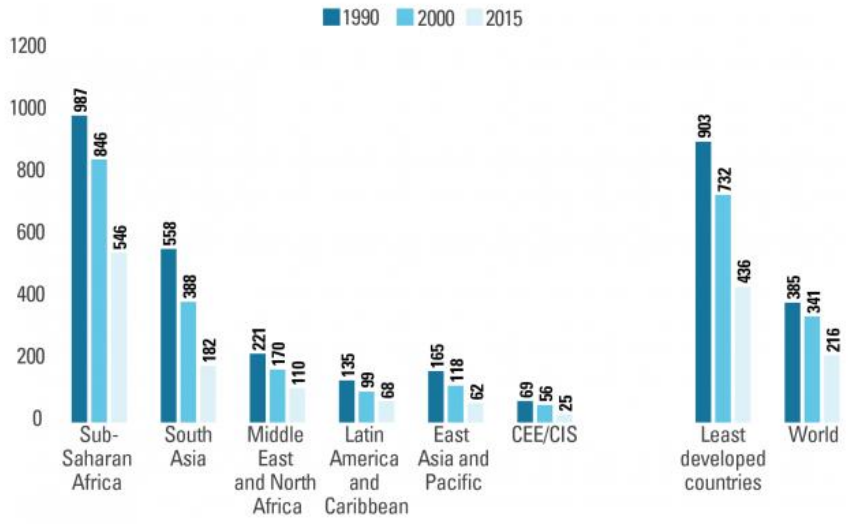

Figure 2: maternal mortality ratios- source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 1990 to 2015, WHO, Geneva, 2015.

The UN report (2011) confirmed that the majority of maternal deaths could be avoided since the largest proportion of such deaths are caused by obstetric hemorrhage, followed by eclampsia, sepsis, complications of unsafe abortion and other indirect causes, which includes malaria and HIV. Therefore, the presence of a trained health-care worker during delivery plays a significant role in reducing maternal mortality. The 2013 UN report indicates that in 2011, about 46 million of the 135 million live births, women delivered alone or with inadequate care. Even if the 2011 coverage by skilled birth attendants increased, the rural-urban disparity persisted -from 44% (1990) to 53% in rural areas, and from 75% (1990) to 84% in urban areas. Rural based women are still at risk in terms of the care that is available as well as they receive. These gaps were even larger sub-Saharan Africa and Southern Asia (UN report, 2013).

Due to the fact that many Sub-Saharan African countries may not be able to attain MDG 5, the African Union Commission (AUC) and United Nations Population Fund-UNFPA initiated CARMMA (Campaign on Accelerated Reduction of Maternal Mortality in Africa) to intensify the implementation maternal health programs that were agreed as part of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. UNFPA also initiated different campaigns and programs such as "No women should die giving life" under its safe motherhood program.

Along with other African countries, Ethiopia is also part of CARMMA. Accordingly, numerous non-governmental organizations (national—as well as international—organizations) have designed different intervention programs and started working in collaboration with the UN, and the national government towards achieving these goals.

3. National Maternal Health Policies in Ethiopia and Trends

In Ethiopia, the overall health status remains poor, given the high rate of morbidity and mortality. The HSDP VI (2010-2015) indicates that Ethiopia has a life expectancy of 54 years, and an infant mortality rate (IMR) of 77/100. In terms of women's health, the MMR has declined from 673 per 100000 (2005) to 590 per 100,000 (2010). The major causes of maternal death identified in the strategic document (HSDP VI, 2010-2015) include obstructed/prolonged labour (13%), ruptured uterus (12%), severe preeclampsia/ eclampsia (11%) and malaria (9%).

In order to tackle these problems, the Government of Ethiopia developed a national health policy followed by a five years comprehensive Health Sector Development Plans (HSDPs), starting from 1996/97. As stated in this plan, democratization and decentralization of the health care system; developing preventive, promotive and curative components of health care; assurance of accessibility of health care for all parts of the population; and encouraging

private and NGO participation in the health sector are the fundamental intentions. However, Ministry of Health report (2013) indicates that implementing this core values in the given time period (2015) is challenging. Despite this challenge, the Federal Ministry of Health has built a structure for improving maternal and neonatal health.

The MoH health extension and education center published the health extension program profile in 2007. According to this profile, the health extension program (HEP) "is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households, which is based on the concept and principles of public health care" (p.3). It is designed to improve the health status and participation of of families, using community based technologies, skills and wisdom, and fewer facility-based services (Health extension and education center, MoH, 2007). The health extension program is also used as a strategic vehicle to address maternal, neonatal and child health interventions in a community. The major objectives of the HEP include:

> 1) improving access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas; 2) Ensuring ownership and participation by increasing health awareness, knowledge, and skills among community members; 3) Promoting gender equality in accessing health services; 4) improving the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs; 5) Reducing maternal and child mortality; and 6) promoting healthy life style" (Health extension and education center, MoH, 2007, p.11).

To provide coverage for the whole country, the government of Ethiopia trained and deployed 30000 Health Extension Workers (HEWs) by 2009. HEWs are responsible for promoting four packages of preventive health services in their community – family health, disease prevention and control, environmental sanitation and hygiene, and health education and communication. Under disease prevention and control, they are expected to address sexually transmitted infections (STIs) including HIV/AIDS; the prevention and control of TB and

malaria, and preform first aid emergency measures. Under family health, they are expected to address family planning, adolescent reproductive health, maternal and child health, immunization, and nutrition. The hygiene and environmental sanitation package include solid and liquid waste disposal, food and water hygiene and safety measures, personal hygiene, healthy home environment, and control of insects and rodents.

Studies assessing the effectiveness of HEWs indicated that HEWs have significant contribution in providing promotive and preventive health services (Datiko & Lindtjørn, 2009; Teklehaimanot & Teklehaimanot, 2013; Wakabi, 2008). However, delivering the whole package is very challenging in terms of guiding time-use, work schedule, reporting, and relationship with the community (Medhaniye et al, 2012; Teklehaimanot & Teklehaimanot, 2013).

Medhanyie and his colleagues (2012) carried out a cross sectional survey that included 725 randomly selected women with under-five children from three districts in Northern Ethiopia in order to assess women's utilization of family planning, birth assistance, pre and postnatal care, HIV testing, and iodinized salt. They also examined the association of several variables such as age, educational status, marital status, and religion, with utilization of maternal health services using logistic regression analysis. The results of this study revealed that 85% of the women have had an antenatal care (ANC) visit at health facility. However, only 48% of the women had the WHO recommended 4 and more ANC visits. Only 5% reported that they gave birth at health facility and had postnatal care. 85% of the women had been tested for HIV and only 13% of the household found greater than 15PPM of iodinized salt. Comparing these results with EDHS 2005, the researchers found an increase in the percentage of women who use family planning, HIV testing and antenatal care; while no change was observed in the percentage of women who have used iodinized salt and facility-based delivery. Therefore, they concluded that despite

HEWs contribution in improving some aspects of maternal health services, their role in increasing facility-based delivery and skilled birth attendance remains questionable.

According to DHS 2010, the maternal mortality rate has declined from about 871/100,000 live births in 2001/02 to 590/100,000 in 2010. In 2010, the coverage for antenatal care reached 59.4%, while deliveries attended by skilled health personnel gotten 20.3% and postnatal care service 25.1%. The national contraceptive prevalence rate was also 55%. With regard to maternal health. Skilled assistance at delivery increased from 6 % (2005) to 10 % (2011) (EDHS, 2011). Nevertheless, the EDHS (2010) also indicate that nine women in every ten deliver at home. From the 10% of professionally assisted births, 4% were assisted by a doctor, 7% by a nurse or midwife, and less than 1% by HEWs. Fifty-seven percent of births were assisted by a relative, or some other person and 28% by a traditional birth attendant, while 4% of births were unattended.

The official MDG progress report by Ministry of Finance and Economic Development (MoFED), (2010) indicated that the major strategy used to achieve the health related goals of MDGs, including improved maternal health, was training and deploying HEWs in rural places. The HEWs are trained in recognition and referral of maternal and newborn complications, essential newborn care and skilled delivery. So far, the total number of HEWs trained and deployed has reached 30,193, which accounts 98 % of the total national requirement. Therefore, the on-going integrated and inclusive interventions in the health sector could have a considerably positive impact in achieving the goal of reducing maternal rate to 267 per 100,000. The major problem reported by MoFED was lack of accurate records to estimate and project maternal mortality rates since, the vast majority of people in Ethiopia give birth at home assisted by traditional birth attendants (midwives). Even the number of new births is itself is an estimate.

Therefore, the accuracy of this progress in reducing maternal mortality is closely correlated with access to health facilities and professionals and the quality of service delivery.

I could not find many studies that examine the effectiveness of maternal health interventions in Ethiopia. However, the few studies I found suggest that even if changes have been registered, maternal health is a pressing problem in Ethiopia. And achieving the MDG target is still far from achievement (Medhanyie et al, 2012; Worku, Yalew & Afework, 2013).

4. Summary

In this section we have seen the vast disparity in maternal mortality rates between developing and developed countries. In developing countries mortality risks range from 1/15 to 1/50, but in developed countries the risk may be 1/4000 to 1/10,000. Almost 90% of maternal death in developing countries could also be averted. Losing mothers, while giving lives, and in conditions that could have been prevented, makes maternal health an issue of human rights and social justice.

We have also assed international and national [Ethiopian] maternal health policies starting with the Safe Motherhood Initiative launched in 1987. Then MDG 5: improved maternal health was discussed in line with the targets and indicators set to monitor and evaluate the progress as well as the effectiveness. However, it was argued that MDGs do not expressly recognize the structural impediments which keep people trapped in poverty and poor health conditions.

Most countries with high maternal mortality rates, including Ethiopia, have inadequate registration systems, since births are carried out in home with the help of traditional birth attendants. These disparities help us recognize the significant role economic and sociocultural contexts play in health and wellbeing [including maternal health]. Efforts to reduce maternal

mortality should pay attention to cultural factors that influence individual's health service seeking behavior, and their access to health services. Intervention programs that promote Safe Motherhood should increase access to high quality antenatal and post-abortion care, skilled delivery care, reproductive health and family planning.

Looking at maternal health, the targets and indicators are only explained in terms of numbers. However, it requires more than numerically explained indicators to address this salient issue. Maternal health require addressing pregnancy related complications, as well as socioeconomic barriers, which entail more than a numerical indicator focused on maternal mortality ratio. Thus, to instigate positive change in maternal health, contextual and culturally relevant policies and interventions that goes beyond MDGs, are needed.

F. Health-Seeking Behavior in Health Policies and Interventions

Studying health-seeking behaviors has become a necessary tool for comprehending how people use the health care systems in their respective demographic, cultural and socioeconomic, circumstances. Thus, it requires decision making processes which is governed by cognitive and non-cognitive factors that necessitate contextual analysis. Contextual analysis examines individual/household behavior, community norms and expectations, as well as economic factors since biomedical knowledge alone cannot guarantee better health (Olenja, 2003; Shaikh, 2008).

Shaikh (2008) also argues that behavioral, social and economic determinants of health need to be taken into consideration throughout program cycle, which starts from crafting campaigns of advocacy, lobbying for a policy changes and persuading donors to commit and invest. This section will briefly discuss different models of health-seeking behavior, and summarize various studies, which examine women's health-seeking behavior in in Ethiopia, and other African countries.

1. Models of Health-Seeking Behavior

Hausmann-Muela, Ribera & Nyamongo (2003) argue that understanding human behavior is prerequisite to change behavior and improve health practices. The most frequently used studies in health-seeking behavior are knowledge, attitudes and practices (KAP) surveys (Hausmann-Muela, Ribera & Nyamongo, 2003). According to Hausamann- Muela and her colleagues (2003), knowledge is assessed to see how far community knowledge corresponds to biomedical concepts. Attitudes result from a complex interaction of beliefs, feelings, and values, which are central to understand health-seeking behavior. Practices are about the use and/or utilization of different health care options. All in all, KAP surveys produce descriptive data, without explanationing why people choose to do what they do (Hausmann-Muela, Ribera & Nyamongo, 2003).

Public health utilizes models informed by social psychology, medical sociology and medical anthropology to explain or predict health-seeking behavior in order to identify problematic areas so as to intervene with specific health system strategies (Hausmann-Muela, Ribera & Nyamongo, 2003). Usually, a health seeking behavior model involves perceived nature of illness, identification of symptoms, and proper home care and monitoring that may necessitate seeking facility-based care, medication and compliance (Olenja, 2003). This section will summarize the mostly frequently utilized models in public health interventions: Health Belief Model, Theory of Reasoned Action, Theory of Planned Behavior, the Health Care Utilization or Socio-Behavioral Model by Andersen, the four A's, and the Pathway Model.

a. The Health Belief Model (HBM)

HBM was developed in the 1950s and still is the mostly used model in public health. Its basic components are derived from a well-established body of psychological and behavioral

theory (Janz, 1984). As explained by Jogin and Albal (2014, p. 2-4) , this model is guided by: (1) Beliefs about the impact of illness and its consequences, which depend on perceived susceptibility, or the beliefs about how vulnerable a person considers him-or herself in relation to a certain illness or health problem; and perceived severity of illness or health problems and its consequences; (2) Health motivation, or readiness to be concerned about health matters; (3) Beliefs about the consequences of health practices and about the possibilities and the effort to put them into practice, which is evaluated depending on perceived benefits of preventive or therapeutic health practices; and perceived barriers, both material and psychological (for example 'will-power'), with regard to a certain health practice; (4) Cues to action, which include different, internal and external factors, which influence action; (5) Beliefs and health motivation that are conditioned by socio-demographic variables (class, age, gender, religion, etc.) and the psychological characteristics of the interviewed person (personality, peer group pressure etc).

Using the HBM it is possible to determine relevant factors for health promotion programs. However, as Jogin and Albal (2014) discussed, HBM neglects further determinants such as: previous experiences, advantages of maladaptive behavior, behavioral intention, and perceived control. Also, it does not explain structural or cultural factors like poverty and traditional and religious norms (Hausmann-Muela, Ribera & Nyamongo, 2003).

b. The Theory of Reasoned Action and the Theory of Planned Behavior(TPB)

Fishbein and Ajzen (1975) developed the Theory of Reasoned Action to understand and predict behavior. The theory assumes that individuals are rational decision makers, and will behave in a manner consistent with their values and the information available to them. The immediate determinant of behavior is an individual's intention to perform the behavior. In turn,

individuals' attitudes towards the behavior and perceptions of the norms surrounding the behavior inform individuals' intentions.

TPB recognize the motivational aspects of personal disease control, influence of social networks and peer pressure in predicting health-seeking behavior (Hausmann-Muela, Ribera & Nyamongo, 2003). However, like HBM, it overemphasizes psychological traits, while under-valuing structural factors like limited access or availability of resources (Hausmann-Muela, Ribera & Nyamongo, 2003).

c. The Health Care Utilization Model

The socio-behavioral or Andersen model (Andersen & Newman, 1973) shifted the individual-level focus to a combination of the individual, the health care system, and the contextual environment. This model theorizes that the use of health care services is determined by a range of societal, health services system, and individual variables. Thus, Andersen & Newman (1973) categorized these variables into three clusters of factors: predisposing, enabling and need factors (Hausmann-Muela, Ribera & Nyamongo, 2003). The predisposing factors include age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc (Jogin & Albal, 2014). Enabling factors include: availability of services, financial resources to purchase services, health insurance, social network support etc (Jogin & Albal, 2014). Need factors include: perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, help from outside for caring etc (Jogin & Albal, 2014). In the later versions, Andersen's model incorporated Health Service System, addition to the predisposing factors and enabling factors referring to the structure of the health care system and its link to a country's social and political macro-system (Hausmann-Muela, Ribera & Nyamongo, 2003). Thus, it linked health-

seeking behavior with structural levels within a macro-political and economic context (Hausmann-Muela, Ribera & Nyamongo, 2003).

The model centers specifically on treatment selection, which includes both material and structural factors, which are barely taken into account in the social psychology models. Andersen's model has been modified in the International Collaborative Study on Health Care by Kroeger in 1983 (Hausmann-Muela, Ribera & Nyamongo, 2003). The Kroeger version includes Health Service System factors, referring to the structure of the health care system and its link to a country's social and political macro-system, which is a valuable extension as it puts emphasis on the link of health-seeking behavior with structural levels within a macro-political and economic context (Hausmann-Muela, Ribera & Nyamongo, 2003). However, the model omits the 'need factors' which are central for understanding health-seeking behavior (Jogin & Albal, 2014).

d. The "four A's"

The '"four A's" model has been widely used by medical geographers, anthropologists and epidemiologists who emphasized social and geographical distance and economic aspects as key factors for access to treatment (Hausmann-Muela, Ribera & Nyamongo, 2003). This model discusses health-seeking behavior based on availability, accessibility, affordability and acceptability. Availability is explained by the geographic distribution of health facilities, pharmaceutical products etc, while accessibility assesses issues related to transportation, roads, and other important infrastructures (Jogin & Albal, 2014). Affordability examines treatment costs for individuals, households or families. Acceptability is related to the cultural and social feasibility mainly referring to the characteristics of the health providers—health workers' behavior, gender aspects (non-acceptance of being treated by the opposite sex, in particular women who refuse to be seen by male nurses/doctors), excessive bureaucracy etc (Jogin & Albal, 2014). The "four A's"

help to easily identify potential 'barriers' for adequate treatment (Hausmann-Muela, Ribera & Nyamongo, 2003).

e. Pathway Models

Pathway models (Good, 1987) center on the path that people follow until they use different health services (home treatment, traditional healer, and biomedical facility). These models stress the importance of 'significant others' and the decision-making process, which challenges the emphasis on the individuals in illness negotiation and management (Hausmann-Muela, Ribera & Nyamongo, 2003). It also acknowledges these dynamics of illness and decision-making depicting health-seeking as a dynamic process (Hausmann-Muela, Ribera & Nyamongo, 2003). Factors are sequentially organized, according to the different key steps i.e. recognition of symptoms, decision making, medical encounter, evaluation of outcomes, re-interpretation of illness, which determine the course of the therapy path (Hausmann-Muela, Ribera & Nyamongo, 2003).

f. The Theory of Triadic Influence (TTI)

The theory of triadic influence (TTI) is one of the integrative theories of health that explains behavior as being the result of three streams of causes of behavior (Flay, 2004). The proponent of TTI, Flay (2004) portrayed the three streams of causes of behavior as intrapersonal, interpersonal, and sociocultural-environmental. According to Flay and his colleague Petrairis (1994), the intrapersonal influences focus on self-determination/control and social skills, leading to self-efficacy, while the interpersonal is geared towards cultural-environmental influences on knowledge and values, influencing attitudes. Sociocultural-environmental causes of behavior focus on social situation/context influences on social bonding and social learning, thereby influencing social normative beliefs. The intrapersonal, personal and sociocultural -

environmental factors flow through three levels of causation: ultimate level, distal level, and proximal level which are interconnected with one another (Flay, 2004; Flay & Petriaris, 1994; Flay, Petriaris & Hu, 1994). Thus, all three streams converge on decisions/ intentions as the final predictor of behavior (Flay, 2004).

Flay and his colleagues (1994; 2004) argue that TTI provides a unifying framework that organizes the constructs from theories of social control and social bonding, social development, peer clustering, personality, cognitive-affective predictors, social/cognitive learning, biological vulnerability, and other integrative theories. Moreover, TTI provides testable hypotheses about causal processes, including mediation, moderation, and reciprocal effects. Therefore, "TTI is useful not only for explaining behavior but also for designing interventions for the treatment or prevention of health compromising or other risky behaviors, the promotion of health-enhancing and other positive behaviors, and positive youth development" (Flay, 2004, p. 715).

Examining the pattern of health-seeking behavior, we can observe that it has different constructs. Client based factors, provider-based factors, including caretaker perceptions, social and demographic factors, cost, social networks and biological signs, and symptoms influence health-seeking behavior (Olenja, 2003). Thus, observing the different models, it is possible to see the progressive shift from individually focused explanation of health-seeking behavior to a more inclusive model that is sensitive to sociopolitical and environmental factors. Various studies show that the more inclusive models better explain health-seeking behavior, in terms of malaria (Hausmann-Muela et al., 1998), HIV/AIDS (Conner & Sparks, 1995), reproductive health (Nash Ojanuga & Gilbert, 1992), especially in developing countries (Ryan, 1998; Weller et al. 1997).

Conversely, Noar & Zimmerman (2005), citing Weinstein, (1993) argue that despite a large empirical literature, "there is still no consensus that certain models of health behavior are

more accurate than others, that certain variables are more influential than others, or that certain behaviors or situations are understood better than others" (Weinstein, 1993, p. 324). Moreover, constructs measured in health-seeking behavior may come from different theoretical and conceptual origins, and have different names, yet when measured they are essentially the same. Therefore, "since so much research on health behavior is theory based, it is crucial that the field 'audit' itself to be sure that we are moving in the right direction" (Noar & Zimmerman, 2005, p.287). Rimer (1997) also argues that "Theory is not theology. Theory needs questioners more than loyal followers" (p. 146). Thus, to further understand health behavior and health behavioral change, it is important to have researchers who are willing to put these concepts and theories to the strongest possible tests (Noar & Zimmerman, 2005). It is also important to keep in mind that there is no one health behavior model that fits all.

2. Community Participation in Health Programs

The idea of community participation in health was first articulated by the World Health Organization (WHO) in the 1970s, since basic health needs in 'Southern' counties could only be met through the greater involvement of local people themselves. Henceforth, this concept has been forged as the cornerstone of the strategy to achieve universal primary health care (PHC). Once solidified in international health policy, many countries adopted community participation as the means by which to address important health problems. Thus, attainment of good health became focused on concepts with underlying democratic vision—concepts like empowerment, health promotion, and collective action, rather than physician centered care and hospital based programs (Zakus & Lysack, 1998).

Community elicits powerful images of a harmonious and equitable place where reciprocity and mutual concern prevail. All things 'community-based' are looked upon

favorably, despite an absence of investigation of the actual features of those groups who are called, or call themselves, communities (Lysack, 1994). Ensuring community participation is salient for community empowerment. No consideration of community participation in health would be complete without analyzing its relation to empowerment and health promotion (Shaikh, 2008; Zakus & Lysack, 1998).

> The historical origins of community empowerment rest with grassroots development projects which perpetuated the idea that empowerment consist of fundamental struggle with powerful groups such as governments who systematically oppress less powerful groups such as the poor and the illiterate. Health promotion, too has strong roots in social philosophy that asserts that the causes of ill health are largely attributed to adverse social conditions, not to insufficient medical care (Zakus & Lysack, 1998, p.8).

The structures and traditions of the formal health system often present major obstacles to meaningful involvement in health promotion and community empowerment activities. Moreover, even if the community has an interest in participating, they often lack technical and financial capacity to contribute and make a meaningful change. Given this context, if empowerment and health promotion efforts fail to adequately address equity and social justice concerns of the community, then they would have no use. Therefore, to be both effective and sustainable, community participation must become an integral part of the community's common experience and not remain as a structure imposed from outside (Zakus & Lysack, 1998). It must be rooted in the expectations of the community, supported by ongoing access to needed and usable information.

In most of the developing countries, where women have a subjugated position in the family, and need to seek the permission the household head to go to health service facilities, it is easy to grasp the wide gaps in the health care system, which is designed contrary to the community's norms and culture (Shaikh, 2008). Therefore, policymakers need to have the

technical knowledge of the diseases as well as the contextual knowledge to understand people's perceptions, which leads to health-seeking behavior.

Luck (2000) also argues pregnancy, complications of pregnancy, and obstetric emergencies occur within the larger context of the local health system. Local knowledge about pregnancy, the etiology of maternal morbidity, and appropriate therapies for these conditions influence how and why formal health services are utilized, but is often ignored in maternal health intervention studies. “Similarly, the complex webs of personal, economic and political factors affecting the provision of maternal health services are generally ignored. Installation of equipment or posting of additional staff are considered sufficient remedies for the inadequate quality of care provided in many health facilities” (Luck, 2000, p.606). Analysis of problems and implementation of maternal health interventions should consider a wider range of factors and use multiple data sources to document both existing systems and how these systems respond to intervention. Moreover, community involvement is a pre-requisite as changes are required at the grass root level health services. Any reforms to revamp the role of primary care and primary health care can only be successful if the reforms are capable of changing public perceptions about health and health care services (Shaikh, 2008).

3. Factors Affecting Maternal Health-seeking Behavior in Ethiopia and Other Developing Countries

Various studies that are carried out in Ethiopia and other developing countries reveal that geographic, socio-economic and contextual factors affect the utilization of maternal health services. Among these factors, women’s autonomy (Woldemicael & Tenkorang, 2010), household income (Amin, Shah & Becker, 2010; Chandrasekhar, Gebreselassie, & Jayaraman, 2011), distance from health facilities and transportation (Okojie, 1994; Karim, Betemariam,

Yalew, Alemu, Mary Carnell, et al, 2010), living in rural or urban settings (Nigussie, Haile Mariam & Mitike, 2004), cost of maternal health services (Osubor, Fatusi & Chiwuzie, 2006), and access to radio (Karim, Betemariam, Yalew, Alemu, Mary Carnell, et al, 2010) were discussed in the findings of the studies reviewed in this section.

For countries like Ethiopia, where maternal mortality data are scarce, use of skilled health personnel during pregnancy and delivery is used as an indicator for measuring the progress in maternal and child health. Therefore, women's status and their involvement in reproductive choices are crucial to utilization of health services as well as addressing their health needs (Woldemicael & Tenkorang, 2010). It is important to ensuring women's autonomy. Women's autonomy is defined as the ability of women to make and execute independent decisions pertaining to personal matters of importance to their lives and their families (Mason, 1995). The most frequently used proxy indicators that are used to measure women's autonomy are education and employment. However, Woldemicael & Tenkorang (2010) argue that women's freedom of mobility, control over household resources, ability to make decisions on household purchases, freedom from domestic violence, participation in child-related decisions, etc. are also crucial to the use of health services.

In Ethiopia women have little or no control over resources. Therefore, the wide income disparity between men and women puts the women in subordinate position, especially in rural areas, where the decision to seek healthcare is largely dependent on the goodwill of their husbands and the extended family (Woldmicael & Tenkorang, 2010).

Woldemicael & Tenkorang (2010) used the 2005 Ethiopia Demographic and Health Survey (EDHS) data to address questions of women's autonomy and reproductive health. In this study, they incorporated the responses of 5,560 currently married women who had their last live

birth in the 5 years preceding the survey. They have analyzed women's health-seeking behavior in Ethiopia in light of physical, demographic, socio-economic, and health related variables. The variables identified for maternal and child health include the use of pre-and post-natal care, access to healthcare services, reproductive behaviors, which includes fertility, fertility intentions, and contraception, and measures of women's autonomy. Other demographic variables such as the age of women at the birth of their last child, birth order of the last child, education and work status of women, and religion were assessed. This study also assessed the impact of physical distance and access to transportation to and from healthcare services on health-seeking behaviors of women in Ethiopia.

The primary independent variable (women's autonomy) considered three behavioral indicators that measure the degree of a woman's autonomy in Ethiopia, which were assessed using the following questions: *w*ho in your family usually has the final say on (1) making large household purchases; (2) making household purchases for daily needs; and (3) obtaining own healthcare? Women were also asked whether they received antenatal care, tetanus injection, and whether delivery of the last birth occurred in a medical institution.

According to the results of this study (Woldmicael & Tenkorang, 2010), 70% of women reported geographic accessibility such as distance and transportation to a health facility was a major problem for seeking healthcare, which is compatible with the findings of other studies (Berhane, Gossaye, Emmelin, & Hogberg, 2001; Karim, Betemariam, Yalew, Alemu, Mary Carnell, et al, 2010; Okojie, 1994). Moreover, the health-seeking behaviors of mothers in Ethiopia are strongly associated with their educational attainment and work status. Women with primary or higher education are about 4 times more likely to seek healthcare (OR = 4.45, 95% CI: 3.86, 5.14, P = 0.000) than their uneducated counterparts. Working mothers are 47% more

likely to seek health care (OR = 1.47, 95% CI: 1.31, 1.65, P = 0.000), compared to non-working mothers. Health-seeking behavior declines as birth order of the last child increases, suggesting that first time mothers are at least 43% more likely to seek care during pregnancy and delivery than mothers of 4-5 or higher order births. They have also discovered a huge disparity in maternal health-seeking behavior across the wealth indices and between urban-rural residences. Mothers from the wealthiest households are 54% (OR = 1.54, 95% CI: 1.05, 2.25, P = 0.026) more likely than those from the poorest households to use antenatal and delivery care services from a medically trained provider. Mothers who reside in rural areas are also less likely to use healthcare services compared to their urban counterparts (OR = 0.78, 95% CI: 0.69, 0.89, P = 0.000) (p.993).

Woldemicael & Tenkorang (2010) also revealed that women's autonomy is a significant predictor of health-seeking behavior in Ethiopia. The results of their study indicated that a unit increase in the autonomy scale increases the odds of seeking health care by 46%. This indicates that women's decision-making power on household matters and their freedom of movement significantly influence their health care seeking behaviors.

These findings are confirmed in other studies carried out in other African countries (Chandrasekhar, Gebreselassie & Jayaraman, 2011; Nigussie, Haile Mariam & Mitike, 2004). Studying maternal health care seeking behavior in Rwanda, Chandrasekhar, Gebreselassie, and Jayaraman (2011), discovered that women continue to deliver at home without professional assistance. In their study, they estimated a multinomial logit model to analyze the factors determining the choice that a woman makes at the time of child birth—deliver at a health facility, deliver at home with professional assistance, or deliver at home without professional assistance. Focusing on births in the 5 years preceding the 2005 survey, they found that a large

proportion (58%) of births in households with the highest wealth class occur in a health facility compared to 20% of births among women from households in the bottom wealth class, which clearly indicate inequality in access to health care. Thus the wealth index is likely to be correlated with access to other infrastructural services including health care. They also found that a greater proportion of births in urban areas occur in a health facility compared to rural areas. Moreover, likelihood of seeking delivery assistance in a health facility increases with increasing level of household wealth as well as education of the woman. There is a strong association between birth order and choice of place of delivery. Their study (Chandrasekhar; Gebreselassie, & Jayaraman, 2011) also confirmed subsequent children are more likely to be born at home without professional assistance rather than at health facility or at home with professional assistance.

Examining adolescents' health seeing behavior during pregnancy and early motherhood, a qualitative study that was carried out in Central Uganda revealed that pregnant adolescents mostly utilize the traditional sector because it is most accessible in terms of distance, cost and cultural context (Atuyambe, Mirembe, Annika, Kirumira & Faxelid, 2010). Atuyambe and his colleagues found that adolescents felt ashamed to meet their peers and feared to visit health facilities. Moreover, as men dominated the decision making process, adolescents felt powerless as they lacked adequate financial and social support. This finding confirms the findings of other studies (Amin, Shah, & Becker, 2010; Karim, et al, 2010; Woldemicael & Tenkorang, 2010) which identified women's autonomy as a significant factor in influencing women's health-seeking behavior. Poverty, lack of power, and decision making influence adolescent's health-seeking practices just like any other women. Atuyambe and his colleagues (2010) also argue that cultural practices and beliefs surrounding birth affect health-seeking behavior. In their findings

they indicated that “cultural prescriptions in relation to placenta rites ‘repelled’ adolescents from seeking delivery services at the health units but acted as an attraction to visit TBAs and herbalists” (p.794).

Summary

Even if there is no one health behavior model that fits all, understanding human behavior, is essential to improve health practices in a given community. So far we have seen how difficult it is to understand human behavior, and to bring about positive health outcomes without considering cultural and socioeconomic contexts. Community involvement is mandatory to understand the cultural and socioeconomic contexts; and ensure sustainable outcomes in health related interventions, including maternal health. Moreover, involving the community leads to grassroots development and community empowerment.

According to the studies reviewed in this section, women’s health-seeking behavior in Ethiopia as well as other developing countries are affected by women’s autonomy, household income/ wealth, distance from health facilities, access to transportation, living in rural or urban settings, and cost of maternal health services. From these studies it was also possible to observe that most developing countries, including Ethiopia, suffer from the ‘urban bias’, where infrastructure including health and schools are mostly concentrated in urban areas although the majority of the population live in rural areas (Atuyambe, et al, 2010; Chandrasekhar, Gebreselassie & Jayaraman, 2011; Karim, et al, 2010; Nigussie, Haile Mariam & Mitike, 2004; Osubor, Fatusi & Chiwuzie, 2006; Woldemicael & Tenkorang, 2010).

Improving the health of women and children of women in Ethiopia will therefore need community based, integrated/holistic approach that requires more than building a health facility and training health professionals. To bring lasting changes in maternal health, it is necessary for

the government and 'development workers' to involve women in the whole process of health interventions, starting from planning, throughout implantation. Moreover, it is important to enhance women's position in the household, increase their income and level of education through income generating activities and encouraging women's and girls' education.

G. The Interface between Policies, Interventions and Grassroots: Indigenous Approaches

The way 'motherhood' is perceived and defined affects the kind of policies and programs, which are emplace to benefit 'mothers'. Therefore, understanding what "motherhood" represents in Africa is important to critically examine maternal health policies and interventions. This section starts with exploring the literature on how 'motherhood' is portrayed in Africa. It will also provide a comprehensive review of literatures on Indigenous approaches starting with definitions of indigenization and the current discourse around it including Indigenous knowledge and methodologies. I have also provided a detailed description of my conceptual framework, structural social work (Mullaly, 2007), which I view as congruent with Indigenous approaches in many respects.

1. Motherhood in Africa

Motherhood has meant different things in different cultures and subcultures today and the use of language in demonstrating Motherhood have further complicated motherhood (Hansen, 1997). The *Oxford English Dictionary* defined a *Mother* as … "who gives birth to a child or seeks protection and control of a child or is affectionately reverenced and looked up to by a child" (Hansen, 1997, p.433). However, such kinds of common-sense views of motherhood(s) as 'naturally' the role of women, has been highly contested. White, Western feminists have oscillated along a spectrum that stretches between attacks on motherhood as a patriarchal

construct and affirmations of it as a valuable identity and responsibility that must be defended against male control and masculinist values, while Black and third-world feminists have sharply criticized the ethnocentrism of much of this debate (Walker, 1995).

Walker (1995) also argued that significance of motherhood is beyond the two dominant themes in the literature: 'collusion with patriarchy' and 'difference' in black and white women's constructions of motherhood.

> The first [collusion with patriarchy] privileges political discourses over an examination of women's own practice and social identity as mothers, while the second [difference in black and white women's construction of motherhood] ignores historical evidence for overlapping meanings and common cultural influences among black and white women in the twentieth century. Motherhood cannot be reduced simply to a role imposed on women by men. While the proponents of 'difference' recognize this, they tend to apply this insight to black women only and to assume that black and white women have operated within quite separate and pure cultural domains (p.417)

Even if there is no consensus on how to conceptualize and theorize motherhood, the attempt to theorize 'the mother' involves more than intellectual energy. It entails an engagement with one's own intimate experiences of being mothered and, in many cases, of mothering.

In this section I will assess how African feminist [womanist] writers have conceptualized motherhood in Africa. Moreover, based on Anderson's (2007) perspective on motherhood that examined the experiences of native/Indigenous women, I would assess how "the three Cs"—Capitalism, Colonialism and Christianity—influenced Motherhood and its conceptualization in Africa. I would like to acknowledge that Africa is a continent with 54 sovereign counties, which has very diverse languages, cultures, traditions, and norms. I used the term 'Africa' in this section to represent the shared history of colonialism and neocolonialism; and its manifestations.

Akujobi (2011) indicated that Motherhood in Africa is often defined as an automatic set of feelings and behaviors that is switched on by pregnancy and the birth of a baby. It is an experience that is said to be profoundly shaped by social context and culture. Motherhood is also

seen as a moral transformation whereby a woman comes to terms with being different in that she ceases to be an autonomous individual because she is one way or the other attached to another—her baby.

The motherhood paradigm is culturally recognized as an autonomous unit in indigenous African constructs of kinship (Walker, 1995). Thus, most African societies have been found to be strongly pronatalists who mandate parenthood (Hollos & Larsen, 2008). Fertility—the capacity to bear children and assume the social identity of motherhood—continues to be very highly valued by women and to inform their choices around motherhood. The fact that value was created by fertility gave women a significant role in society, not only as the objects of exploitation, but as bearers of value in the technical as well as the wider, non-technical sense.

Akujobi (2011) also argued that giving birth bestows a certain status on women—even mystical powers in some ethnic groups like the Yoruba in West Africa, as motherhood symbolizes fertility, fecundity, and fruitfulness. In this sense, Motherhood is a sacred as well as a powerful spiritual component of the woman's life.

a. Beyond Fertility: Motherhood in Africa

A mother [woman] is the primary upholder of the native culture since she teaches the child about the society's ways of knowing and doing things. Thus, the woman-as-mother becomes significant to the development and maintenance of the community (Akujobi, 2011). Walker (1995) confirmed that women as mothers are life-givers. Thus, the work and the responsibilities of motherhood are to nurture, to preserve, and to protect. Walker (1995) also argued that 'Motherhood' embraces at least three different terrains, which may be inter-related. The first she highlighted as mothering work, which is the biological practice of motherhood—giving birth to a child. The second terrain is the discourse of motherhood, embracing the norms,

values and ideas about 'the Good Mother' that operate in any one society or sub-group. The third dimension is the examination of motherhood as a social identity, with 'social identity' being understood as 'consisting of those aspects of the individual's self-image, positively or negatively valued, which derive from membership of various social groups to which she belongs (Walker, 1995).

Motherhood in Africa also carries several extended and more public meanings. In various West African communities, birthmothers of children and women of a certain age or stature could informally be known widely in their communities as ‘Mother’. In Yoruba societies, the local term for ‘mother’ often serves as part of the official title of women priests and royal ministers, and in the names of both ‘witches’ and divine or sacred women (Semley, 2012). This notion of ‘public mothering’ (Semley, 2012) embodies a power that may conjure the deep symbolism of childbirth without requiring biological motherhood.

Motherhood is also an integral part of the definition of women in all societies, and as such the social organization of women around this issue in terms of maternity rights, child care etc is central to the emancipation of women. Therefore, the emphasis was not on women as nurturers within the privatized family but on women collectively as the mothers of the next generation (Walker, 1995). It appears that the respect and authority a woman is bestowed to her by virtue of her role as a mother—and falls strictly within the sphere of the household.

To think of public mothers discursively also requires an understanding of changing local and colonial constructions of women’s power and vulnerability (Semley, 2012). Walker (1995) also indicated that there are many who believe that a woman cannot realize her position in its dual capacity of homemaker and of citizen, and who believe that in trying to fulfill both duties she must fail in one.

> However, it is through the sacredness of her calling in the home and the strong maternal instincts born in every true woman that we shall find the more she rises to the full development of her nature, the better will she take her position in the destinies of the world and the country of which she is part (Walker, 1995, p. 418).

b. The Three Cs: Colonialism, Capitalism and Christianity in Defining African Motherhood

Traditional African societies were ethnic nationalities. Authority is exercised through a system of chieftaincy, clan elders and heads of households, and the social support system was based on mutuality and accepted reciprocity since the economy was based on land and kinship systems (Rankopo & Osei-Hwedie, 2011). There were no private-public dichotomies and hierarchies, gender roles are interdependent, equally valuable and flexible, and decisions were made for common goals valuing cooperation and collaboration. Moreover, in indigenous societies, older children and elderly play significant roles in child rearing, and there was interdependency between families and networks of women (Anderson, 2007).

Indigenous societies [including Africans] acknowledge the diversity within the Indigenous people although they still share values, epistemologies, worldviews, and history (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). History is very important in understanding African society. As Said (1993) said "Past and present inform each other, each implies the other and each co-exists with the other. Neither past nor present has a complete meaning alone. How we formulate or represent the past shapes our understanding and views of the present (p. 4)". Thus, understanding colonialism and its manifestation is crucial in construction of motherhood in Africa.

1) Colonialism and Capitalism

In Africa, Colonialism disconnected people from their histories, landscapes, language, social relations and their own ways of thinking, feeling and interacting with the world (Thiong'o,

1994; Tuhiwai Smith, 2012). It further destroyed existing structures and social support systems which were based on mutual respect and reciprocity through introducing Capitalism (Rankopo & Osei-Hwedie, 2010). The African system of chieftaincy that comprise ethnic nationalities organized around kith and kin, the social support system was adequate to meet most requirements as it was based on mutuality and accepted reciprocity (Rankopo & Osei-Hwedie, 2010). However, Capitalism, which is based on competition, increasing capital, free market economy, relegated the sense of cooperation and reciprocity from the African culture. It promoted money as the medium for exchange of goods and services; widened the distinction between the homestead and the workplace; and reduced the importance of mutual reciprocity as the basis of welfare (Rankopo & Osei-Hwedie, 2010). Within the new structure [of capitalism] mothers (women) lost their place and position.

Within the current context of globalization, Indigenous people could not simply return back to their traditional governance structures because of the change in the socioeconomic and political environment (Harrison, 2001). Nevertheless, Africans still kept many dimensions of their collectivist culture. Collectivism as cultural pattern emphasizes the extended family, community, caste, tribes, country, etc (Haj-Yahia & Sadan, 2008). Members of collectivist societies have a sense of obligation to their collective community. Their personal satisfaction, self-actualization, and fulfillment is defined in reference to their community; and accordingly they are able to maintain harmony with their collective (Haj-Yahia & Sadan, 2008).

In the fight to win sovereignty in the era of colonialism as well as neocolonialism, Anderson, (2007) argued that Motherhood can be used as a form of resistance and a key for self-determination and rebuilding of Indigenous nations. For indigenous women, pregnancy and giving birth could be a response to the cultural genocide, involuntary sterilization and stealing of

children their parents and grandparents experienced. Being a mother has implicit and explicit meaning in the family, spirituality and relationships. Accordingly, most African societies have been found to be strongly pronatalists who mandate parenthood (Hollos & Larsen, 2008). The motherhood paradigm is also culturally recognized as an autonomous unit in indigenous African constructs of kinship (Walker, 1995).

If we examine the development of African literature, the existing power imbalance in the global arena, coupled with a history of slavery, colonialism, and continuous exploitation and marginalization in the global arena still has an impact in the development and theorizing of motherhood in Africa. Western literary yardsticks are still used to judge and determine the unique literary cultural contributions from Africa (Wehrs, 2002). Therefore,

> An African literary perspective must battle against external factors which influence and taint the thought process: Western acculturation, powerful political and technological resources, near one-dimensional economic globalization with its concomitant cultural imperialism (Wehrs, 2002, p.63).

To better understand the structural issues in Africa, we need to know the history of colonialism and its vivid manifestations to date. The huge class and gender differences within a country, the conscious, systemic and systematic oppressions can only be fully understood when we understand the past.

2) Christianity

In indigenous societies, the maternal body has been used as a metaphor of power-creation as well as ability to sustain it hence; giving birth was understood as “sacred work” of women. However, Christianity decentered women from this process and introduced ‘God the Father’ instead of ‘Mother the creator’ (Anderson, 2007). Christianity is also [mis]used to support colonialism spreading an individualistic notion that supports capitalism.

Motherhood in Africa has to be viewed as an identity that for women is infused with a separate meaning and carries an independent appeal (Walker, 1995). However, with the introduction of Christianity in African communities, wifehood and motherhood started to be equated or analyzed in the same terms. Walker (1995) eloquently explained this notion in South Africa saying:

> Even if Motherhood was central to African women's personal and cultural identity as well as their social and economic roles long before the advent of Christian missions, the church groups served to transform, elevate and entrench the importance of marriage, wifehood and motherhood for women (p.432).

African feminism has been grounded in lived experience, beginning from the very essential needs for daily survival like clean water and education (MakuchiNfah-Abbenyi, 1997). Thus, African feminisms emphasize the power and agency of African women in particular to theorize from their cultures and lived experiences to produce knowledge that is contextually relevant, builds relationships, and heals the self, the community and the larger socio-cultural context. MakuchiNfah-Abbenyi (1997) further argues that through these experiences, African writers revealed the complicated gender politics and women's oppression, which is engraved in the patriarchal sociocultural and economic systems. Therefore, African Feminism is open to learning from the new global agenda of feminism(s), and teaching a (Eurocentric) Feminist movement a few things as well. Through this experience, African women writers portrayed the complexities of gender politics, seeking to create a space for themselves, rather than 'duplicating' or 'writing back' to radical feminism.

African women tend to see feminism as a form of 'imperialism with a woman's face', which imposes or dictates its views and visions on African or 'Third World' women (MakuchiNfah-Abbenyi, 1997; Chilisa & Ntseane, 2010). For Emecheta and Ba, who are prominent African women writers, women's subject-hood and sexuality is intrinsically linked

with that of men (MakuchiNfah-Abbenyi, 1997). Thus, many African women prefer the term womanism to feminism, arguing that the term feminism is associated with Western ideologies (Chilisa & Ntseane, 2010; MakuchiNfah-Abbenyi, 1997).

c. Summary

Motherhood is intertwined with the socio-cultural and economic contexts. The reviewed articles in this section confirmed that culture plays a significant role in shaping the discourse on motherhood in Africa. Cultural imperatives in different spheres, from economic systems to marriage, family, and religion, are realities in all societies. The way in which societies grapple with these issues and other pressing demands constitutes the foundation of culture (Wehrs, 2002). Recognizing the huge influence culture has in shaping ideology and epistemology, the construction of motherhood in Africa needs more clarity and depth in analyzing different traits that are associated to motherhood and the overall politics surrounding this paradigm. The differences within a country as well as the systemic oppressions can only be fully understood when we understand the past. Peoples' fight for survival can be addressed if we are able to solve the structural issues and take culturally appropriate measures.

Our perceptions guide our action. Pettigrew (1987) reminds us that "…where we sit not only influences where we stand, but also what we see" (p. 649). Thus, the way we perceive and define 'motherhood' would impact the kind of policies and programs we develop in order to benefit 'mothers'. In developing maternal health programs, should we focus on the biological definition of motherhood, which is liked to giving birth to a child or, the social and more inclusive one, which considers women in general as mothers of the society?

Examining maternal health programs, as stated in the MDGs and in Ethiopian Ministry of Health documents, they are mostly linked to prenatal, natal and postnatal services. Although

there is no universal meaning for motherhood, examining the contextual meanings of motherhood in Africa would broaden the perspectives and perception of policy makers. Thus, understanding the context will help in addressing structural problems, which thereby address individual needs.

2. Indigenous Knowledge and Approaches

Indigenization is the development of culture-specific knowledge and practice (Gray & Coats, 2010). It is about developing local, empirically based knowledge about culturally appropriate solutions to particular contexts (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). Thus, it is against the attempt of 'internationalization' and 'standardization' replicating the Western theories, concepts, and methods everywhere (Gray & Coats, 2010; Rankopo & Osei-Hwedie, 2011). Gray & Coats (2010) further argue that Indigenization is a naturally occurring process—characterized by assimilation and resistance. "It can also be understood, as it is in postcolonial studies, as a process of decentering colonial discourse and power structures through tactics that can be resistant or more confrontational" (p. 623).

Gray, Coates, & Yellow Bird (2008) shifted the discourse around indigenization to cultural relevance. They argued that indigenization is an outmoded approach since it is about adapting imported ideas to fit local needs. Indigenization must be viewed against historical processes of globalization and colonization. Thus, it is important to move to authentization, which is a culturally appropriate approach that requires becoming genuine, or going back to one's roots to seek direction, moving away from adopting and modifying Western social work theory and practice (p.5). Therefore, in trying to apply this framework, "academicians and researchers need to recognize their privilege, validate Indigenous wisdom, acknowledge

Indigenous rights and discard the power they exert in the name of the profession" (Faith, 2008, p.83)

a. Indigenous knowledge

Indigenous knowledge and practices are locally shared (Chilisa & Ntseane, 2010; Gray & Coates, 2010; Sen, 2005; Silliote & Marzano, 2008; Tuhiwai Smith, 2012). However, knowledge is not homogenous as differences exist along gender, age, class, caste, occupational and other lines, and between individuals of similar social status (Silliote & Marzano, 2008). Indigenous knowledge also comes from a range of sources embedded in community practices, institutions, relationships and rituals and is a dynamic mix of past tradition and present innovation, which makes it ever evolving, and usually tacit (Durie, 2004; Getty, 2010; Sen, 2005; Silliote & Marzano, 2008).

Several scholars (Durie, 2004; Getty, 2010; Sen, 2005; Silliote & Marzano, 2008; Tuhiwai Smith, 2012) uphold that Indigenous knowledge is diffused and communicated in everyday life. Silliote & Marzano (2008) argued Indigenous knowledge "is equally 'skill as knowledge' as people transfer much through practical experience, and are often unfamiliar with, or do not need to, express all that they know in words. Indigenous people may also carry knowledge, and pass it between generations, using unfamiliar idioms featuring symbols, myths, rites and so on" (Silliote & Marzano, 2008, p.15). Thus, Indigenous knowledge involves understanding, which is rooted in the local culture (Chilisa & Ntseane, 2010; Escarcega, 2010; Gray & Coates, 2010; Silliote & Marzano, 2008; Tuhiwai Smith, 2012).

Adopting from Ellen and Harris (1996), Sen (2005, p.376) identified six traits that distinguish Indigenous knowledge:

1. It is local as it is rooted in a particular community and situated within broader cultural traditions; it is a set of experiences generated by people living in those communities. Separating the technical from the non-technical, the rational from the non-rational could be problematic. Therefore, when transferred to other places, there is a potential risk of dislocating Indigenous knowledge.
2. It is tacit knowledge and, therefore, not easily modifiable.
3. It is transmitted orally or through imitation and demonstration. Codifying it may lead to the loss of some of its properties.
4. It is experiential rather than theoretical. Experience and trial and error, tested in the rigorous laboratory of survival of local communities constantly reinforce Indigenous knowledge.
5. It is learnt through repetition, which is a defining characteristic of tradition even when new knowledge is added. Repetition aids in the retention and reinforcement.
6. It is constantly changing, being produced as well as reproduced, discovered as well as lost; though it is often perceived by external observers as being somewhat static.

Gretty (2010) argues that the ontological foundations of indigenous worldviews are "based on the 'system model' with the assumption that a) the ecosystem is a dynamic, ever-changing, everlasting system that adapts to changing circumstances; (b) each system has many parts; and (c) the whole is more than the sum of its parts" (p.8). "Thus, there are no hierarchical structures; all living things, including rocks, vegetation, animals, and people are related and interact in a reciprocal manner… The cosmos is perceived to be a moral, compassionate, knowledgeable entity that teaches people lessons" (p.9). For most indigenous peoples the fundamental starting point is a strong sense of unity with the environment (Durie, 2004). The Indigenous worldview

also considers all life sacred and humans exist to respect and care for all other living beings, focusing on the collective rather than on individuals (Harrison, 2001; Tuhiwai Smith, 2012; Gretty, 2010).

Gretty (2010) also affirms that Indigenous knowledge arises from observation and interaction with the biological and social environments, as well as from visions, stories, and spiritual insights. Therefore, knowledge among Indigenous peoples, "is perceived to be eternal; it can be retrieved when needed and recede from consciousness when not required" (p.11).

So far, there is no consensus on what defines being Indigenous. The 'politics of Indiginity', as Escacega (2010) calls it, requires the (re)construction of peoplehood and negotiating concepts used by nation-states. Analyzing the history of The Working Group of Indigenous People (WGIP), which is under the United Nations, Indigenity was defined based on the current state of colonization. Indigenous people were those who are still colonized, disregarding many countries in Africa and Asia that have undergone decolonization assuming that they have achieved self-determination (Escarcega, 2010). However, this definition was contested by African representatives in the WGIP for ignoring the oppression of Indigenous groups within 'decolonized' societies (Duri, 2004; Escarcega, 2010). However, Durie (2004) argues that "the defining characteristic of indigenous peoples is not necessarily premised on colonization or sovereignty or a prior claim to settlement, but on a longstanding relationship with land, forests, waterways, oceans and the air. … In this sense, indigeneity can be conceptualized as a state of fusion between indigenous peoples and their accustomed environments" (p.1139).

b. Indigenous Methodologies

Methodology is important because it frames the question being asked, determines the set of instruments and methods to be employed, and shapes the analysis (Denzin & Lincoln, 2008;

Matsinhe, 2007; Nicholls, 2009; Tuhiwai-Smith, 2012). Matsinhe (2007) argues that "methodology legitimates and delegitimates, validates and invalidates, approves and disapproves, passes and fails, claims to knowledge and knowledge production. Methodology is the exercise of power to include and exclude, that is, the erection of boundaries and gate keeping" (p.389).

Writing about Indigenous research methods and methodologies, Cardinal (2001, cited in Gretty, 2010, p. 182) noted

> Indigenous research methods and methodologies are as old as our ceremonies and our nations. They are with us and have always been with us. Our Indigenous cultures are rich with ways of gathering, discovering, and uncovering the knowledge. They are as near as our dreams and as close as our relationships.

Matsinhe, (2007) also affirm that Indigenous knowledges are virtually littered with virtualities. The interweaving of the actual and the virtual, the here and the hereafter, the physical and non-physical worlds abound in indigenousness (Matsinhe, 2007; Tuhiwai Smith, 2012). For Tuhiwai Smith (2012) her respondents are experts of their everyday lives. For them, the physical and non-physical were equally real, and they drew from both to construct their social reality. However, 'Western' methodologies only acknowledge things that are perceivable by the five human senses—taste, touch, sight, smell and audition—as legitimate evidence of knowledge. The rest—such as gods or spirits—is dismissed as fictitious (Matsinhe, 2007; Silliote & Marzano, 2008; Tuhiwai Smith, 2012). In non-western societies spirituality and aesthetics structure the multitude's life (Matsinhe, 2007). To substantiate this claim, Metsinhe (2007) gives an example where the Senegalese traditional doctors recite The Healers' Manifesto periodically; perform the Circle of Union, an aesthetics mediated rituals and The Door of No Return, an emotionally charged psycho-spiritual therapy for African slave melancholia and alienation (p.841).

Indigenous research protocols require building relationships and collaborations between the researcher and research participants so as to forge trust, equity and partnership in the whole process (Kovach, 2010). This research paradigm is appropriate to the needs of Indigenous communities in their struggle for self-determination as it can emancipate social change (Kovach, 2010). Indigenous inquiry is always grounded in principles centered on autonomy, home, family and kinship as it presupposes a shared collective community vision (Denzin & Lincoln, 2008).

In Indigenous research, "questions are framed differently, priorities are ranked differently, problems are identified differently, and people participate on different terms" (Tuhiwai-Smith, 2012, p. 196). The most important question in Indigenous research is Indigenous struggle for social justice. Semali and Kincheloe (1999) confirm that "Indigenous knowledge is a rich social resource for any justice-related attempt to bring about social change" (p. 15). That struggle is what "life feels like when people are trying to survive in the margins, to seek freedom and better conditions, to seek social justice" (Kovach, 2010, p.199). Therefore, Indigenous methodology is also a tool for social activism and theory, which can be mobilized as resistance and transformation (Davis, Williams & Akinyela, 2010; Morgensen, 2012, Semali & Kincheloe, 1999). Moreover, Nicholls (2009) argues that Indigenous methodologies require relationality, and multilayered reflexivity. Researchers need to challenge their traditional notions of objective control between researchers and research participants. Nicholls (2009) also identified three layers of reflexivity (p. 121)—self-reflexivity, interpersonal reflexivity, and collective reflexivity. "By practicing the three layers of reflexivity, there is an opportunity to reframe notions of justice, empowerment and participation within research as a paradigm of relationships that nurture self-determination, whereby the individual person is constituted through his or her communicative and interactive relations with others" (Nicholls, 2009, p.121).

This process requires Indigenous methodologies to interrogate colonial academic procedures (Morgensen, 2012).

For Tuhiwai Smith (2012) research is one of the ways in which the underlying code of imperialism is regulated as well as realized. It is regulated through the formal rules of individual scholarly disciplines and scientific paradigms, and the institutions that support them (including the state). It is realized in the myriad of representations and ideological constructions of the Other in scholarly and 'popular' works, and in the principles that help to select official histories and school curricula (Gretty, 2010; Matsinhe, 2007; Tuhiwai-Smith, 2012). Indigenous research is not socially, or politically, neutral (Silliote & Marzano, 2008). Moreover, it should not be taken as pre- or anti- science (Matsinhe, 2007). Indigenous research challenges the so called objective, value-free, and scientific process for observing and analyzing human reality, due to the emphasis placed on deterministic models of analysis and its denial of culture as a mediating force (Davis, Williams & Akinyela, 2010; McCleland, 2011), Tuhiwai-Smith, 2012).

c. Indigenous Approaches in Development

In its annual development reports, the World Bank acknowledges that knowledge is the key to sustainable social and economic development. Thus, Sen (2005) argues that building on local knowledge is the first step to mobilize capital. Development, in the past decades, has been continuously criticized for it expert-led, top-down approaches, which failed bring the desired change (Midgley, 1990; Silliote &Marzano, 2008).

Western oriented policies and intervention approaches tend to be more focused on individuals, ignoring the cultural, communal, and spiritual values that are central to indigenous communities (Midgley, 2008). Since international policies are being adopted, most of the policies in African counties failed to address structural problems that are specific for the counties

(Chogugudza, 2004). Adopting SAP by many Sub-Saharan African countries had unintended negative consequences, especially in relation to privatization and land use perpetuating unilateralism and imperialism (Midgley, 2008). Land grabbing by multinational mining corporations and mechanized agricultural industries displaced indigenous people—what Senga (2010) called "accumulation by dispossession and displacement". According to Senga (2010), large mining corporations dispossess land and natural resources from local small-scale miners in turn forcing them to retaliate against foreign investors, which often results in bloodshed. National policies, therefore, needs to reflect on structural issues giving due attention to the sociocultural and economic realities of citizens.

Silliote &Marzano (2008) and Midgely (1990, 2008) argue that the perpetuation of inappropriate interventions is partly due to the failure of politicians and policy makers to realize the complexity of development and the contextual nature of problems, which vary across culture and history. Politicians also fail to acknowledge there is no tailor-made or generic 'solution' to these problems.

Indigenous knowledge is heterogeneous and complicated, which is an inconvenience for development (Silliote & Marzano, 2008). Nevertheless, as an approach to incorporating an understanding of socio-cultural contexts within which local knowledge and practices are set, indigenous research helps to avoid replicating futile programs (Harrison, 2001; Midgley, 1990, 2008; Silliote & Marzano, 2008). Hence, there is a growing interest in Indigenous knowledge development, which is largely driven by ensuring sustainable development practices in developing countries, as well as concerns about loss of bio-diversity (Sen, 2005).

It is important to acknowledge that Indigenous Knowledge development has various challenges. Silliote & Marzano (2008) pointed out that incorporating local knowledge and values

into the development process, which is dominated by foreign ideas and hierarchy, require substantial time, effort and resources. Indigenous knowledge is neither static nor uniform. Its dynamism makes its representation difficult. And, its specificity hampers its incorporation in development. Moreover, at the current state, indigenous knowledge research currently lacks any conceptual or methodological coherence since the spectrum of indigenous knowledge studies is fragmented.

Despite this challenge, Silliote & Marzano (2008) affirmed that Indigenous knowledge research plays a significant role in facilitating meaningful communication between development staff and local people, "informing outsiders about local knowledge and insiders about what scientific technology offers, so that both can better understand the alternatives and realize their comparative advantages" (p.17). As a result, Indigenous knowledge research has proved effective in places where NGOs have worked closely with local people to develop effective technology interventions (Silliote & Marzano, 2008).

d. Important Considerations in Indigenous Approaches

In the search for relevance in social and economic policies, the starting point must be the community, the bedrock of culture. Indigenous approaches are about developing local, empirically based knowledge regarding culturally appropriate solutions to particular contexts (Chilisa and Ntseane,2010; Davis, Williams & Akinyela, 2010; Gray & Coats, 2010; McCleland, 2011, Rankopo & Osei-Hwedie, 2011). Thus, Indigenous approaches require decolonizing the process of research, policy formulation and intervention program planning (Chilisa and Ntseane, 2010; Escarcega, 2010; Matsinhe, 2007; Nicolls, 2007).

Decolonizing is not a onetime event, but a process of decentering colonial discourse and power structures (Gray & Coats, 2010). The process of decolonization requires ethically and

culturally acceptable approaches to the study of issues involving indigenous people, whereby the underlying assumptions, motivation and values that are enacted with imperialism and colonialism will be criticized (McCleland, 2011; Tuhiwai-Smith, 2012). Therefore, decolonization is about indigenizing methodologies, which involves a commitment to an authentic approach that requires becoming genuine, or going back to one's roots to seek direction, moving away from adopting Western theories and practice approaches (Gray & Coats, 2010; Thiong'o, 1994).

Within the current context of globalization, Indigenous people could not simply return to their traditional governance structures because of the change in the socioeconomic and political environment (Harrison, 2001). Thus, developing indigenous approaches requires a balance, challenging dominant models of social work practice and research, while integrating traditional values and practices that have withstood centuries of oppression into culturally consonant forms of service and inquiry. It must be emphasized that decolonization does not negate collaboration with external partners and experts, and seeking resources for capacity-building.

Indigenous approaches consider diversity, history, culture, and contemporary realities (Weaver, 1999). Culture defines people's daily life and patterns of interaction (Chilisa & Ntseane, 2010; Durie, 2004; McCleland, 2011). Africa is a culturally diverse continent. Cultural and linguistic difference even exists in a country. For example, the languages spoken in Ethiopia are more than 80; in Nigeria, 250; Ghana, 76; South Africa, 23; and Botswana, 28 (Rankopo & Osei-Hwedie, 2010). Religion and spirituality also play significant roles in individuals as well as communal life (Rankopo & Osei-Hwedie, 2010; Gretty, 2010). Thus, in this process, it is important to pay attention to diversity, social structures and patterns of communication. Secular approaches that ignore these facts will not effectively address the social problems. There no one

policy and/or intervention program or a practice guideline that can be used and replicated everywhere yielding similar results (Midgley, 2008; Silliote &Marzano ,2008; Sen, 2005; Weaver, 1999).

Weaver (1999) argues that history is an important component in the process of indigenization. “Past and present inform each other, each implies the other and each co-exists with the other. Neither past nor present has a complete meaning alone. How we formulate or represent the past shapes our understanding and views of the present (Said, 1993, p. 4, cited in Gray & Coates, 2008)”. To better understand the structural issues in Indigenous communities, including those in Africa, we need to know the history of colonialism and its vivid manifestations to date (Tuhiwai Smith. 2012; Weaver, 1999).

Policy, research and practice in Africa, including Ethiopia needs to pay attention to local realities of the communities most of which reside in rural areas and with a collectivist culture. For most people in Ethiopia, living in rural areas has always been a fact of life. However, rural economies, and people who live in rural areas, have always been missed in national development priorities and in some cases relegated to second-class citizenship (Osei-Wusu & Buor, 2012). The UNFPA (2007) report estimated that by 2025, the rural population of Africa is expected to increase from 510 to 702 million. Therefore, regardless of the phenomenal growth of cities and increasing rural urban migration in the developing world, the rural communities will continue to harbor a significant proportion of the population of Africa (Osei-Wusu & Buor, 2012).

In applying Indigenous approaches, it is important to allow different ways of knowing challenging the recognized epistemology (Silliote & Marzano, 2008; Tuhiwai-Smith, 2012). Tuhiwai-Smith (2012) argues that Indigenous research challenges the so called objective, value-free, and scientific process for observing and analyzing human reality, due to the emphasis

placed on deterministic models of analysis and its denial of culture as a mediating force. The process of knowing is at times more important than the results, especially working with Indigenous people (Denzin & Lincoln, 2008; Tuhiwai-Smith, 2012).

e. Summary

Indigenous approaches require a move to authentization, which is a culturally appropriate approach that requires becoming genuine, or going back to one's roots to seek direction, moving away from adopting and modifying Western social work theory and practice. In this process, the starting point must be the community, the bedrock of culture. Indigenous approaches consider diversity, history, culture, and contemporary realities since Indigenous people could not simply return to their traditional governance structures because of the change in the socioeconomic and political environment (Harrison, 2001). Thus, developing indigenous approaches requires a balance, challenging dominant models of social work practice and research, while integrating traditional values and practices that have withstood centuries of oppression into culturally consonant forms of service and inquiry. Therefore, Indigenous approaches can serve as an intersection bringing policies, interventions and the grassroots together.

3. Structural Social Work

Structural social work has evolved from helping people to modify situation that limit their functioning (Middleman & Goldberg, 1974), to dealing with discrimination through advocacy within the given political and organizational arena (Davis 1991, cited in Mullaly, 2007), then to changing of existing structures that perpetuate inequality (Mullaly, 2007). The purpose of social work is "to improve the quality of transactions among clients and their physical and social environments, in ways that are consistent with social justice" (Mattaini, 2008, p.355). Social justice as viewed by this approach entails fair distribution of goods and resources, as well

as efforts to confront/overcome any norm, social condition, social process, or societal practice that interferes with or constrains one from fully participating in society (Mullaly, 2007). Structural social work is built on the fundamental values of humanitarianism and egalitarianism, which are the bases of social democracy that adhere to the socialist paradigms (Mullaly, 2007). Its acknowledgement to the importance of social justice and social democracy make it well-suited to Indigenous approaches.

Mullaly (2007) indicated that "the ultimate goal of structural social work is to contribute to the transformation of society calling for transformation of sociopolitical and economic relations that are based on classism, sexism, racism, patriarchy, imperialism, to sociopolitical and economic relations based on equality among all social groups (Mullaly, 2007, p.248).

When it is applied to practice, structural social work employs intrapsychic and interpersonal processes, in order to counteract the damaging effects of oppression, and build strength in the individual for developing community of solidarity (Mullaly, 2007). Structural social work also includes consciousness-raising and collectivization, which are critical elements in critical liberation. Individual work, group work, or community work could be used separately or in some combination to pursue these goals (Mullaly, 2007).

Like Indigenous approaches, structural social work recognizes the importance of history and acknowledges that "neither the life of an individual nor the history of a society can be understood without understanding both" (Mills 1959, cited in Mullaly, 2007, p. 295). Therefore, I will be using structural social work to shape my analysis, since maternal health is liked to human rights and social justice, which require more than treating an individual patient and providing the health needs of an individual. This framework will also help me to suggest

alternative proposals to improve maternal health in a potentially more effective and sustainable manner, based on the recommendations of research informants.

4. Conclusion

Ethiopia has remained a poor country due to the impact of [neo]colonialism and cultural imperialism. A combination of poor management of the state, natural calamities, imbalanced international trade etc. has left the country with poor indicators of health funding, health system performance, health status and gross inequality in resource distribution (Maurizio, 2007).

Assessing the impact of imperialism and its manifestation in colonialism, liberalism, globalization and Western forms of research, Indigenous approaches are crucial for Africans, including Ethiopians. In this process, policy makers are required to recognize their privilege, validate Indigenous wisdom, and discard their power as professionals and scholars (Briskman, 2008). Therefore, Indigenous approaches can serve as an intersection bringing policies, interventions and the grassroots together. It is important and empowering for people to articulate their problems and contribute their share in solving their problems, since they know their problems, their potential and capacities as well as the sociocultural and economic context better. Otherwise, relying on the Western model and policies that are prescribed for us, the socioeconomic problems in Sub-Saharan Africa, including Ethiopia, are likely to continue to persist in greater magnitude. In fact, African countries will replicate imperialism and [neo] colonialism by using these top-down policies. *The Master's tools will never dismantle the master's house (Lorde, A. 1979).*

Different studies have been carried out in Sub-Saharan Africa to know the effectiveness of Safe Motherhood Initiatives. Counties also carry out monitoring and evaluation studies, and report their findings using MDGs standard indicators. However, those studies rely on secondary

data from hospital records and estimate aggregate results using advanced statistical analyses that are of limited value for data with extremely limited reliability and validity. Nonetheless it is clear that Sub-Saharan Africa was not be able to meet the goals set under MDG5. What does this mean to the people [target groups]? It is important to know how 'mothers', who are the targets of this international goals [SDG 3.1; MDG5], define their needs, and to know to what extent their needs have been met by the available services. It is also important to examine their perceived barriers (if there are any), and their proposed solutions to overcome the barriers identified.

Thus, my study will try to address these gaps in the research, responding to the research questions: 1) How do mothers who are intended to benefit from maternal health policies and programs define their needs? 2) To what extent have their needs been met by maternal health policies and programs, community resources and traditional practices? 3) What interventions have helped the most? 4) What gaps, if any, remain in interventions; what do mothers think would improve their situation? using qualitative research methods. In so doing, I used structural social work theory and indigenous research approaches to inform and shape my research questions as well as analysis.

III. RESEARCH METHODOLOGY

A. Research Design and Method of Investigation

The main purpose of this research is to examine the interface between maternal health policies and their implementation at the grassroots in Ethiopia, and evoke workable strategies and recommendations that might be used to establish Indigenous, i.e. culturally competent, policies and programs. As outlined in the preceding literature review, maternal health is a human rights and social justice issue that requires a holistic and contextual understanding of motherhood, maternal health needs and maternal health services. It is also argued that maternal health policies in Ethiopia are influenced by international policies such as: Sustainable Development Goals (SDGs) and Millennium Development Goals (MDGs), which are largely neoliberal and neocolonial policies imposed by the UN without adequate contextual analysis. To understand the cultural context and actual needs of the community, it is important to go back to the community and learn from the mothers, who are targets of maternal health policies, about their needs and their priorities. It is also important to acknowledge their autonomy since they are better informed and aware of their context than any policy expert. Sheehan (2011) argues "Autonomy generates a more complex, reflexive, and adaptive organizational state through individuated and diverse responses than could be achieved through any imposed understanding or central locus of control" (p.69).

This study used qualitative research methods informed by Indigenous research approaches. Qualitative methodologies provide a space to capture the voices of the grassroots valuing both process and content (Kovach, 2010). Qualitative methodologies also allow substantial flexibility in research design and data analysis, nurturing reciprocal relationships with participants, while enhancing their collaboration and participation in local development and

action (Kovach, 2010). Indigenous methodologies can also be situated within the qualitative landscape, because they require participant-level engagement and accept autonomy of the grassroots – research participants (Sheehan, 2011).

Indigenous knowledge and research methodologies "have always been with us" and "Indigenous cultures are rich with ways of gathering, discovering, and uncovering knowledge" (Cardinal 2001, 182). Tuhiwai-Smith (2012), Fixico (2003), and Sheehan (2011) also argue that Indigenous knowledge accepts diversity as the basis of creativity and adaptation, and is situated in place and accumulated over time. In using Indigenous methodologies, it is possible to addresses issues of politics, identity, culture, and the history of people in relation to the lands they inhabit. Hence, Indigenous values are incorporated throughout the research process, and local norms and traditions are respected as research opens up to a broader range of perspectives.

In order to gather the data necessary to understand maternal health needs and resources available in the community, and the gap in service delivery and utilization, in-depth, semi-structured interviews were held with women who live in the community. These women have been targets of international as well as national maternal health policies and programs, however they did not take part in the development of these 'expert-led' policies and programs. With this in mind, this research used in-depth interviews, to benefit from the profound personal and meaningful connection in-depth interviews create, and to acknowledge the autonomy of research participants as experts of their own context, allowing them to teach all of us [researchers and policy makers] the complex issues surrounding maternal health in their community.

I also used observation to understand interpersonal relationships as well as individuals' relationships with their place and all the creation. Wilson (2001) argues that Indigenous knowledge is shared with all creation. Knowledge "is not just interpersonal relationships, not

just with the research subjects I may be working with, but it is a relationship with all creation. It is with the cosmos, it is with the animals, with the plants, with the earth that we share this knowledge" (p. 177). Understanding maternal health requires understanding the complex sociocultural, economic, emotional and spiritual features of motherhood, mothers' relationship with their environment, and their health service seeking behavior.

B. Sampling and Recruitment

1. Study Location

The study is carried out in *North Wollo Zone,* Ethiopia. The Federal Democratic Republic of Ethiopia is located in the Horn of Africa bordered by Eritrea to the North, Djibouti and Somalia to the East, Sudan and South Sudan to the West, and Kenya to the South. According to the World Bank data (2015) the current population is projected to be 99,390,750. The Federation is composed of nine regional states (killil): Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations Nationalities and People Region (SNNPR), Gambella and Harari Regional States; and two Chartered Cities - Addis Ababa and Dire Dawa. The national regional states and the two city administrative councils are further divided into 67 *Zones,* 800 *woredas* (districts) and around 15,000 *kebeles* (smallest local administrative unit) organized under farmer associations in rural areas (10,000 *Kebeles*) and urban dwellers associations (5,000 *Kebeles*) in towns (Ministry of Foreign Affairs, http://www.mfa.gov.et).

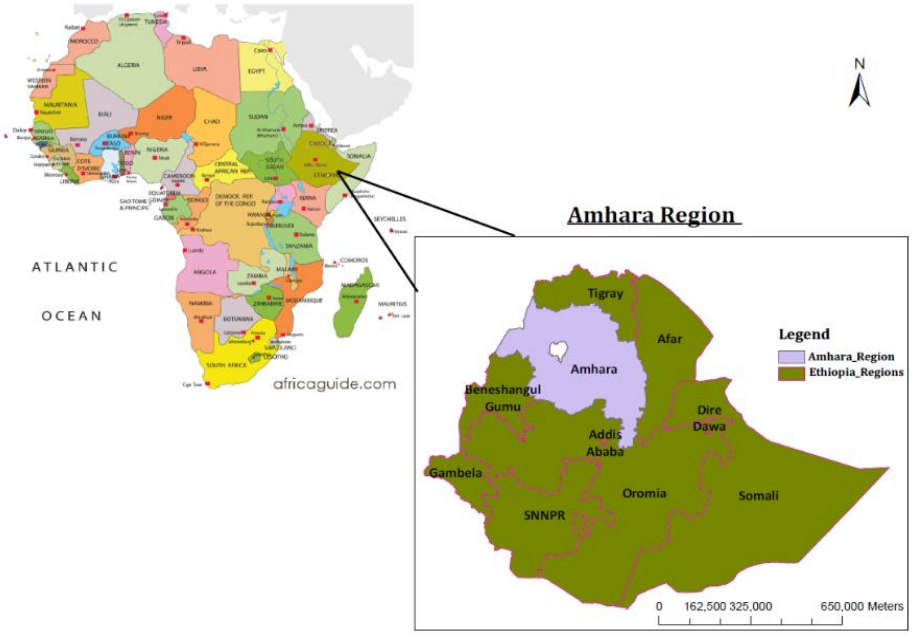

Figure 3. Ethiopia, Regions of Ethiopia and the Amhara region

North *Wollo* is one of the 67 *Zones* in Ethiopia, and one of the 10 zones of Amhara Region that is found in Northern Ethiopia. North *Wollo* is administratively divided into eight *woredas* with an estimated population of 1,500,303. In an assessment report the World health organization (2000) indicated that there are two hospitals, eight health centers, sixty-two health stations and thirty- three health posts. From the 8 *woredas* in North Wollo, the interviews were carried out in six: Habru, Gubalafto, Meket, Gidan, Raya Kobo and Lasta. I could not travel to the other two due to time and budget constraint.

I picked North Wollo due to my prior relationship with the community, the place, and the culture. As explained earlier I know the area very well and still have relationships with several program directors and community leaders. I also had a research assistant, Melkam Zemed, who helped me in recruiting gatekeepers and research participants as well as coding de-identified data. Melkam was the perfect choice as a research assistant for this research for various reasons. He is originally from *North Wollo* and still work in the Zone, hence he knows

the cultural contexts and nuances in the community. He also has an MA degree in economics and works as a program director for Professional Alliance for Development (PADet), an Indigenous non-governmental organization. As a professional, he understands the policies and programs designed and implemented to enhance maternal health in Ethiopia. Before the research started, he completed the necessary training in human subject research, Indigenous methodologies, and qualitative research analysis, emphasizing coding and the overall process.

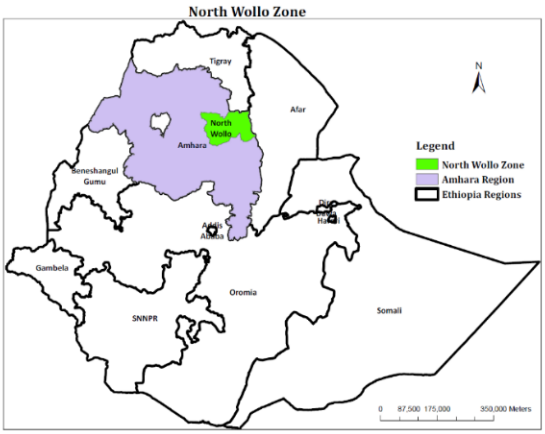

Figure 4. Amhara Region and North Wollo Zone

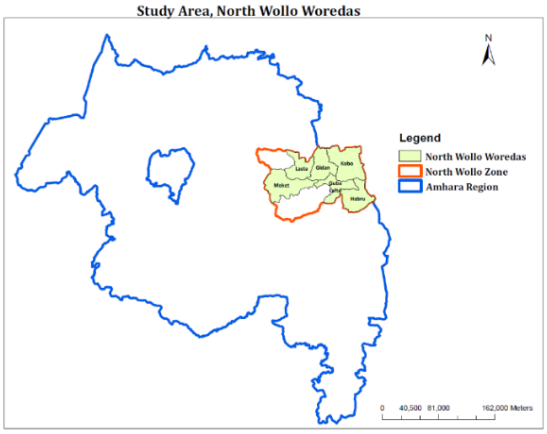

Figure 5. North Wollo Zone, Study Locations

2. Selection and Sampling

Any health related research needs to be approved by the Zonal Health Bureau. My relationship with PADet gave me an easy access to the Zonal health bureau to get a permit to carry out my research. Once the permit was secured, I started identifying and contacting gatekeepers with the help of my research assistant. In qualitative research, gatekeepers are used to assist the researcher in gaining access and developing trust with the community of study (Hatch, 2002). Indigenous research protocols also require that research participants become research collaborators integral to each step of the research so as to forge trust through an emerging relationship that fosters equity (Kovach, 2010; Sheehan, 2011; Tuhawi-Smith, 2011).

The gatekeepers that were used in this study included: elders and community leaders, religious leaders, administrators, and service providers, in order to ensure enough variation amongst the participants as they have different circles of influence.

During the first time meetings with the identified gatekeepers, my research assistant was with me. His presence facilitated better communication, understanding and connection with gatekeepers, since he has personal relationships with the gatekeepers. After the first meeting everything wet smooth since I was no longer considered a 'stranger'.

The only criteria to be part of this study were identifying as women, 18 years old and above, and currently residing in North Wollo Zone. With the help of gatekeepers, we purposefully identified 30 potential research participants to ensure variation among participants. For first contacts, gatekeepers introduced me to potential research participants. Then, I arranged informal introductory meetings [without the presence of gatekeepers] with potential participants to build rapport and ensure their voluntary participation. During these meetings, I introduced myself, clarified the purpose of the research, and discussed consent forms. I also assured potential participants that I would never share their decision whether to participate or not with gatekeepers, so that they do not feel pressured to participate in the study. Indigenous research protocols require that research participants, normally addressed as 'research subjects', become research collaborators in every research process so as to build trust and foster equity. Thus, having informal introductory sessions with potential research participants encouraged relationship building and collaboration.

After securing their voluntary consent to participate in this study during the informal meetings, I scheduled another meeting for the interview. Interviews were conducted in everyday settings, with 27 women (18 years old and above) living in *North Wollo Zone,* Ethiopia.

Community members, traditional birth attendants, community volunteers, health extension workers, government officials, NGO workers, and nurses were included in this study, hence, research participants had different socioeconomic, spiritual and academic backgrounds. From each of the six *woredas*, I interviewed at least four women. I stopped after 27 interviews since the data reached saturation, i.e., when new themes, or explanations stop emerging from the data (Creswell, 1998).

C. Data Collection

1. Interviews

Data was collected using in-depth, semi-structured individual interviews with 27 women in North Wollo. DiCicco-Bloom & Crabtree (2006) assert that individual in-depth interviews allow the interviewer to deeply explore social and personal matters, and "co-create meaning with interviewees by reconstructing perceptions of events and experiences" (p.314). Moreover, in Indigenous approaches "best evidence arises from the *researched* when they maintain possession and control of their information, formulate and apply their own language for description and analysis, and engage authentically in ways that provide opportunities for new self-conceptions" (Sheehan 2011, p.77). With this in mind, interviews were carried out in *Amharic* which is the language used [and the mother tongue for most of the dwellers] in *North Wollo Zone*. Amharic is also my mother tongue. The recognition of languages and cultures as living processes is an important aspect of Indigenous methodologies (Tuhawi-Smith, 2011).

To effectively gather my data, I lived in North Wollo for about 12 weeks. During these 12 weeks, I traveled a lot and used different forms of transportation: buses, minibuses, bajajs (three wheeler motorbikes), horse carriages. I used *Woldia*, the major city in North Wollo, as my station since it has easier access to public transportation compared to other cities. Some

settlements in *North Wollo* can only be accessed in dry seasons, and only in a 4-wheel drive car. Other locations have no infrastructure at all, in which cases I walked an average of 2 hours [one way].

Interviews were carried out individually in a convenient place and time for the research participants since women are generally overburdened by their daily routines. Interviews settings used include: research participants home, at their backyard or front yard, in a class room, in an office, and under the shadow of a tree in a school compound or an office. The research participants picked the places and I had to respect their choices since these settings were more natural, safe, and comfortable to them than arranging interviews in artificial settings. Sheehan (2011) affirms that "like any living thing, social and environmental space has exterior apparent conditions and internal hidden processes that are essential to the life of the space and all life within. Social and natural environments share these relational dimensions, where the most significant elements are often hidden from view" (p.70). Hence, respecting the natural space and research participants' choices was very important for this study as it is the core of Indigenous knowledge and methodologies, supporting autonomy and inter-reliance between social and environmental spaces.

Research participants took part in a one-time in-person interview that ranged in length from 40 to 90 minutes. The interviews were recorded using a digital audio recorder and all participants provided consent to record before the interview began. I also took notes during the interview to remind me of any reactions I had during the interview. I also used visual dialogues during the interview. Visual dialogue is a visual and interactive process used to investigate cultural, social and environmental practices (Sheehan, 2011). Sheehan (2011) argues that "in the

same way that birds are related and continue through 'nest,' humans are related and continue through 'design'" (p. 71).

Research participants were asked to express certain concepts and their feelings through drawings or using natural settings as a metaphor or a symbol. They were asked to use different colors, and/or rocks, leaves, and sticks, which ever they are comfortable with to express themselves visually. The visual expressions were then photographed and documented. As Sheehan (2011) explained, "visual dialogue is most valuable because the structure of learning/inquiry promotes emergence, negates normative concepts of power and control, and requires no schooling" (p. 74). It is also "a deep activism because it goes beyond political contestation and resistance to reveal and play out cultural assumptions; thus, everyone experiences the influence that assumptive structures have in everyday practice (Sheehan, 2011, p.72)". In this research, using visual dialogues gave more richness to the data and enhanced research participants' collaboration. It also gave research participants the space to create their own meanings in a way they can relate and is natural to them.

2. Observation

Wilson (2001) argues that knowledge "is not just interpersonal relationships, not just with the research subjects I may be working with, but it is a relationship with all creation. It is with the cosmos, it is with the animals, with the plants, with the earth that we share this knowledge" (p. 177). Therefore, I used observation to understand interpersonal relationships as well as individuals' relationships with their place and all their environment, how their environment affects their access and utilization of maternal health services.

My observation was guided by an 'observation log' where I marked the presence or absence of accessible roads, transportation (public transportation, kind of transportation – car,

bicycles, motorbikes, animals), household energy supply and access to clean water (electricity, solar, gas, and/or biogas), means of communication (mobile phones, land lines, internet, fax, post offices), and public or private facilities (schools, hospitals, open market places, grocery stores, places of worship and rituals). The items in the observation log were selected because they have direct or indirect impact on maternal health. Access to roads, transportation, public and private facilities influence women's access and utilization of maternal health service. The access to energy supply- such as electricity influence women's access to the media and their awareness on national health related policies. Access to electricity, gas and clean water supply also reduce women's household burden, which is related to their health. I visited various places of worship and open markets to see how women interact and carry out their routines, and to understand their role and position as girls, mothers, and elders in their community. I also visited different health posts, health centers and one hospital to see the kind of services delivered in those facilities, and get some sense of the interaction between health professionals and service users, especially at the information desk and the waiting area. In general, observation helped me to better understand the cultural nuances, gendered roles, communication patterns among and between different groups, and the influence of physical space in access and utilization of maternal health services.

Field notes and observations were documented from the first day. I also kept a reflective journal. According to Morrow and Smith (2000), the use of a reflective journal adds rigor to qualitative inquiry as the investigator is able to record her reactions, assumptions, expectations, and biases about the research process. This process helped me capturing the sociocultural, economic and physical differences in the interview settings, thereby providing additional data for the analysis.

D. Data Analysis

1. Data Preparation and Management

All the qualitative interview data were transferred to computer digital audio files after each interview was completed and then deleted from the digital audio recorder. Each audio file was saved in a file named with their assigned pseudo names. Then, I transcribed all interviews verbatim. As Reissman (1993) argued the process of transcribing allows the researcher to become acquainted with the data. In addition to knowing the data better, transcribing the interviews assured the accuracy of the transcripts. As mentioned earlier in this chapter, all interviews were carried out in *Amharic* (native language), hence they were transcribed in Amharic. Due to technical difficulties, I hand wrote the transcripts, eliminating information that could jeopardize participants' confidentiality, and scanned the hand written documents. Each transcribed interview was saved as an individual file under their assigned pseudo names. All information that may link participant information with their assigned pseudo names was stored in a protected location. After I finished transcribing, the de-identified interviews were imported into a computer-based qualitative analysis software, ATLAS ti (Version 7.5.11), in order to manage, sort and code the data. During the data collection, I also kept a journal of my reflections. The reflection journals, field notes, and observation log were used to supplement the information gathered from the in depth interview and as check points to ensure authenticity of the data.

2. Data Analysis

This study used Miles, Huberman, and Saldana's (2013) interactive model to shape the analysis process. This model involves three concurrent flows of activities that consist of data condensation, data display, and conclusion drawing/verification. Miles, Huberman, and Saldana (2013) define data condensation as "the process of selecting, focusing, simplifying, abstracting,

and/or transforming the data that appear in the full corpus (body) of written-up field notes, interview transcripts, documents, and other empirical materials" (p. 12). They argue that data condensation is a form of analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that "final" conclusions can be drawn and verified making data "*stronger."* The process of data condensation starts even before the real data collection while choosing the research questions or conceptual frameworks, and continues until a final report is completed. During data collection, data condensation occurs while writing summaries, coding, developing themes, generating categories, and writing analytic memos.

Accordingly, I started coding the transcribed materials. Codes are shorthand devices used to label, separate, compile, and organize data (Charmaz, 1983). I used my research assistant in coding and identifying themes to better understand and capture all the important nuances in the data. Using someone from the community in the data analysis process also gave the data more life, and strengthened the Indigenous voice. First we coded the first five interviews together, then we coded the rest of the data set separately, and compare our codes to check if we have similar themes or not. Our comparison was mostly similar and whenever there were differences we talked about them and came to a similar code. However, I modified the codes several times as interviews continued and common themes started to emerge.

As Miles, Huberman, and Saldana (2013) lay out, I started sorting and comparing the coded materials to identify similar phrases, relationships between variables, patterns, themes, categories, distinct differences between subgroups, and common sequences. The identified similar code phrases were then grouped together to create clusters. I sorted similar code phrases under different families in ATLAS ti, which are patterns and recurring themes in the narratives.

This process isolated patterns and processes, and commonalities and differences (Miles, Huberman, & Saldana, 2013; Strauss & Corbin, 1990).

The second flow of activity is data display. According to Miles, Huberman, and Saldana (2013) "a data display is an organized, compressed assembly of information that allows conclusion drawing and action" (p.12). They argue that using cumbersome texts to display qualitative data overloads our information-processing capabilities and preys on our tendencies to find simplifying patterns as the texts tend to be sequential rather than simultaneous. Miles, Huberman, and Saldana (2013) proposed using matrices, graphs, charts, and networks. These techniques of data display allow detailed representation and cross case analysis. The displays can also hold a great deal of readily analyzable information. Therefore, in addition to the thick text descriptions, I used photographs, diagrams, and flowcharts to display the data.

The third stream of data analysis is drawing and verifying conclusions. Miles, Huberman, and Saldana (2013) argue that the researcher interprets what things mean by noting patterns, explanations, causal flows, and propositions from the start of data collection. Thus, drawing conclusions is a process that starts early in the data collection process, while maintaining openness and skepticism until it gets to be explicit and grounded at the end. Hence, I grounded the data analysis in the research questions and the conceptual framework that guides the study – Structural Social Work Theory (Mullaly, 2007) and Indigenous Methodologies (Tuhiwai-Smith, 2013), while remaining open to unexpected results. Structural social work is compatible with Indigenous methodologies since both of them acknowledge people's right to power and self-determination. Structural social work is a critical social theory because 1) it is critical of existing social, economic, and political institutions; 2) it seeks to change them; and 3) it articulates alternative social visions consistent with progressive social work values in which life is free of

domination (Mullaly, 2007, p. 215). Structural social work also emphasizes social justice and equity, which is consistent with Indigenous knowledge and methodologies. Semali and Kincheloe (1999) affirm that "Indigenous knowledge is a rich social resource for any justice-related attempt to bring about social change" (p. 15).

Every conclusion need to be crosschecked and verified. As Miles, Huberman, & Saldana, (2013) highlights "verification may be as brief as fleeting second thoughts crossing the analyst's mind during writing, with a short excursion back to the field notes, or may be thorough and elaborate, with lengthy argumentation and review among colleagues to develop intersubjective consensus" (Miles, Huberman, & Saldana, 2013, p. 12). Hence, for this study I used memoing and member checks to verify my conclusions. Memos allow researchers to capture ideas, to describe expectations and assumptions and to advance the analysis (Birks, Chapman, & Francis, 2008).

3. Procedures for Ensuring Trustworthiness

I used member checks to verify my analysis, decrease the chances of misrepresentation, and increase local validity. Revealing the analyzed data to the participants ensures that the researcher has accurately translated their viewpoints into data (Krefting, 1991). For member checks, I used Circles or "yarning circles" as Sheehan (2011) describes it using Aboriginal vernacular. Circles are conducted under the simple rules that each person speaks in turn, holds authority for the time they speak, and reciprocates by speaking responsibly from self and not about others; thus, circles provide equal sharing space where deep equity can be achieved (Boyes-Watson, 2008; Sheehan, 2011). Thus, using circles create a space where participants share their knowledge and experience without restraint. Sheehan (2011) further argues that "deep equity requires methodologies that devolve the inherent power of leadership and equalize

engagements across the research context. This stand may be contested, but if we adopt this position as a first step, our dominance over the context is minimized, and data are less centered on designer/researcher assumptions, projections, and desires." (p.70). With this premise, I shared my primary data analysis with 8 research participants to ensure equity, accuracy as well as accountability using Circles.

Circles often use of a taking piece: a meaningful and symbolic object used to regulate communications (Ball, Caldwell & Pranis, 2012). Ball, Caldwell & Pranis (2012) further explained that participants who hold the talking piece can talk, while others listen. Receiving the talking piece from a person sitting next to you symbolizes an invitation to share knowledge and experiences with the whole group. Therefore, this process allows participants to share what they want at their own pace since they can remain silent, or pass their turn by giving the talking piece to the next person. A talking piece is usually brought by the facilitator or the "circle keeper". However, it was very difficult for me to pick something that is culturally relevant and symbolic to mothers in North Wollo. Even if I know the culture and understand it, I am not originally from this specific region, and every research participant knows that. Therefore, I requested one of my research participants, Emama Fate, who is a respected elderly, to bring a talking piece. She kindly agreed to bring 'something' that could be used a talking piece for the discussion.

The members check was done with 9 research participants, including myself. In circles, facilitators or 'Circle keepers' are counted as participants since they contribute to the co-creation of meanings and understandings. I started the conversation by explaining the values of circles and regulations we all needed to follow during the process. Then, I passed the talking piece to Emama Fate, who sat next to me, asking her to explain the symbolic value of the talking piece she brought, which is followed by other research participants.

The talking piece she brought is called “chocho*”* or “mijuye”. It is a gourd that is used to store milk or yogurt. As research participants explained, the gourd is natural: you plant it, it will grow, and you harvest it when it is ripe. “Chocho” or “mijuye” is also used as a sacred symbolic piece that is given to a bride from her mother when she lives her parent’s house, as a wish for her to be fertile and have a peaceful life. Hence, this talking piece has significance to the discussion topic – Maternal health.

Starting the discussion by explaining the talking piece was a great conversation starter. Everyone was happy and excited to share their wisdom and experience in relation to the cultural significance of the talking piece – “mijuye”, weddings, having children after marriage, and issues related to [in]fertility, which are all related to maternal health directly or indirectly.

Figure 6. Mijuye or chocho

Then, I presented my analysis section by section and everyone gave me their feedback on the content as well as the presentation. I audio recorded the whole session and took notes in the process. Hence, discussion shaped the presentation of my finding chapters. Before the member check I never thought of assigning a section to discuss traditions and rituals related to birthing. After members check I realized how important traditions and rituals are to mothers, and

participants suggested to discuss them in detail. Thus, I have a whole section in my results that discusses rituals and traditions during pregnancy, birthing and after birth.

Doing a Circle for the member check was a very delightful experience for me. I realized the rich Indigenous knowledge and wisdom within the community. I also witnessed the excitement in my participants to talk about the significance of their spirituality and culture; to voice their needs and expectations; and to educate us as to why there is a gap in maternal health service delivery and utilization. This process also ensured participants' contribution and ownership of the co-constructed meanings of motherhood, the assessed maternal health needs, the gaps in service delivery and utilization, and the proposed recommendations to enhance maternal health in their community, which added more richness to the findings.

E. Human Subjects Protection

This study was approved by the University of Illinois at Chicago Institutional Review Board (IRB) in order to ensure the protection of participants (see Appendix K). The research participants were clearly informed the purpose and procedures of the study as well as the risks and benefits of their participation.

Participation was voluntary. Once we identified potential research participants with the help of 'gatekeepers', I arranged informal introductory sessions. The informal introductory sessions were used to explain the purpose of my research, discuss consent form and build rapport. The consent form was written in Amharic, the native language so that research participants could read and understand it (see Appendix D). For those who cannot read and write, I read the document for them and explained it. All participants got a copy of the form as well. To avoid the risk of coercion, 'gatekeepers' were not informed about potential participants' decision

to participate or not participate in the research. Also, gatekeepers were not part of the interview process.

The interviews took place in preferred location of participants and all precautions was taken to ensure privacy. When participants chose a public setting such as: a back or front yard of their house or schools or offices, the risk for their confidentiality and privacy was explained to them so that they can make an informed decision about their preferred location.

All interviews were carried out and transcribed by the primary investigator. All data were de-identified immediately after transcription and pseudonyms were assigned in order to adequately conceal the identities of participants. Part of the data was shared with the research assistant after it is de-identified and replaced by pseudonym to facilitate coding and preliminary analysis.

Interview data was temporarily stored on a digital recorder. Then, this data was erased from the digital recorder after the files were transferred onto a password-protected computer in encrypted files. All storage devices containing data were located at the home office of the principal investigator, these include locked file cabinets, a password-protected computer, and digital audio recorder. This office is locked and no other individual besides the principal investigator has access.

Although this research involved minimal risk, some questions may intrigue past experiences and emotions. Hence, participants were informed that they could skip any questions they do not want to reply, and/or take a break at any point during the interview, or discontinue their participation anytime without facing any consequences. Moreover, as a trained and experienced counselor working with mothers, I have been prepared to recognize any emotional and psychological need that might emerge during the interview and help participants identify

local sources of support. Participants were also monetarily compensated for their time and expertise.

IV. FINDINGS CHAPTER I: BIOLOGICAL AND SOCIOCULTURAL IMPRESSIONS OF MOTHERHOOD

A. Introduction

The purpose of this study was to examine the interface between policy and grassroots, with particular focus on maternal health in Ethiopia, and to elicit workable strategies and recommendations that might be used to establish Indigenous, i.e. culturally competent, policies and programs by responding to the following research questions:

1. What supports does a mother need? In other words, how do the mothers, who are intended to benefit from maternal health policies and programs, define their needs? [program based needs, community resource needs, spiritual needs, and needs based on traditional practices]
2. To what extent have their needs been met? [By maternal health policies and programs, by community resources and traditional practices?]
3. What has helped the most?
4. What if any gaps remain? What do mothers think would improve their situation?

In the coming three chapters, I will present the findings associated with these four research questions. The first findings chapter: Biological and Sociocultural Impressions of Motherhood, describes my journey to North Wollo as a researcher, and the background of my research participants, and examines definitions and concepts, as well as rituals and traditions that surround motherhood. The second chapter: Maternal Health Needs, Available Services and the gaps in service delivery, present the maternal health needs, community based as well as policy led facility based services that are available, and the identified gaps in these services. The third finding chapter: Maternal Health: Who Is Responsible? And How Can We Enhance It? portrays

the deliberation of research participants to enhance maternal health in their community and who needs to take this responsibility.

As explained in the methodology, the findings are analyzed and presented through the interactive model that involved data condensation, data display, and conclusion drawing/verification. In order to ground the findings in participants' voice, the descriptions include numerous quotations from in-depth interview transcripts, and visual dialogues that are represented by photographs and rich narratives. Interviews were carried out in Amharic, the native language, hence the original transcripts are documented in Amharic. The quotations used in this document are equivalent translations and modulations, not literal translation, of the Amharic version, which are used alongside the original Amharic versions. I placed the Amharic version within this text to pay respect to the original voices, to ensure authenticity and allow Amharic speakers access the original data rather than my translation since some idioms may be lost in translation due to cultural difference. In addition, descriptions include conceptual maps, observation notes and my own reflections.

This chapter describes my journey as a researcher and observations, the community, the location, the process of identifying research participants and their background. It also examines definitions and concepts, as well as rituals and traditions that surround motherhood.

1. From an 'Expert' to 'Amateur': My Journey as A Researcher

North Wollo is not a strange place for me. For about 2 years, it had been one of my frequent work trip destinations. Before I started my PhD at Jane Addams College of Social Work in August 2011, I worked for an Indigenous non-governmental organization called Professional Alliance for Development (PADet) leading two large community based intervention programs:

HIV/AIDS prevention, care and support [funded by Geneva Global as part of PEPFAR], and enhancing women's and girls' reproductive knowledge through girls' education (funded by the David and Lucille Packard Foundation), implemented in North Wollo. Although I worked from the head office in Addis Ababa, I had to travel at least every quarter for about two weeks to meet with the regional and field staff as well as the community for various purposes [training, planning, budgeting, reporting, supervision, monitoring and evaluation]. Hence, North Wollo was like a second home for me and I was very familiar with the locations, the language, the people and the norms and traditions.

Figure 7: Habru Woreda- the point of entry to North Wollo from Addis Ababa

However, this trip to North Wollo as a 'researcher' was so different and intense. I was full of contrasting emotions—happy, sad, anxious, excited, and sometimes lost. When I traveled for work, I would I have a car and driver assigned to pick me up from home and take me everywhere I would like to be during my field trip [as long as it is accessible by vehicle]. I was someone with status, a 'program advisor' with a supervising role—I was the 'expert'. But this time, I had to take a bus that departed at 5am from the station at Addis Ababa, which is about 1-

hour drive away from me. And I am a student researcher [with very limited status] who is there to learn. This difference was real and the whole journey has been a very humbling experience.

My first stop and the final destination of the bus was Woldia, the capital of North Wollo Zone, located at the elevation of 6929 ft. Woldia has historically been an overnight stop for travelers heading further north to Lalibella, and truckers. Hence, there are numerous hotels, cafés, internet kiosks and small stores. Woldia also hosts the zonal referral hospital—Woldia hospital, Woldia University that started functioning in 2011, and The Sheikh Mohammad Al Amoudi Stadium, [one of the largest stadiums in the country and near its completion now], Zonal government offices and institutions along with magnificent Churches and Mosques. PADet's regional office is also located in Woldia. My first contact in North Wollo was my research assistant, Melkam Zemed Wudassie, who works for PADet as a regional coordinator.

I went to PADet to meet with Melkam and greet my colleagues the next day. I was so happy to see almost every staff member I knew and worked with 4-years ago. I really appreciated the staff recruitment strategy of PADet since the staff retention, in the current volatile NGO environment, is the result of recruiting experts who are from the community (North Wollo in this case). So long as there is a conducive work environment, the staff is always at home! Most of them received raises and were transferred from satellite offices to the regional office.

I discussed my research with Melkam and took him through the IRB training. Then we prepared detailed plans on who can be used as a gate keeper, where to go to conduct the interview, logistics that are required, and the budget. We also agreed to start the interview in October, once the sun is out and the holidays are over [September has a couple of celebrations since it is the beginning of the new year in Ethiopia].

I returned back and stayed in Woldia for about three months (from October 7 – January 5, 2015). Even if there are some locations that are too far from it, I picked Woldia as temporary home because access to public transportation was easier and I could coordinate a ride with PADet regional office whenever there was an event or a field visit.

North Wollo has eight Woredas[1]. From the eight, I traveled to six Woredas: Habru, Gubalafto, Meket, Gidan, Raya Kobo and Lasta, to carry out my interview and observation. I could not travel to the other two due to time and budget constraints. Map **2** shows the regional as well as zonal map of North Wollo and highlights the Woredas I did my interview and field observation.

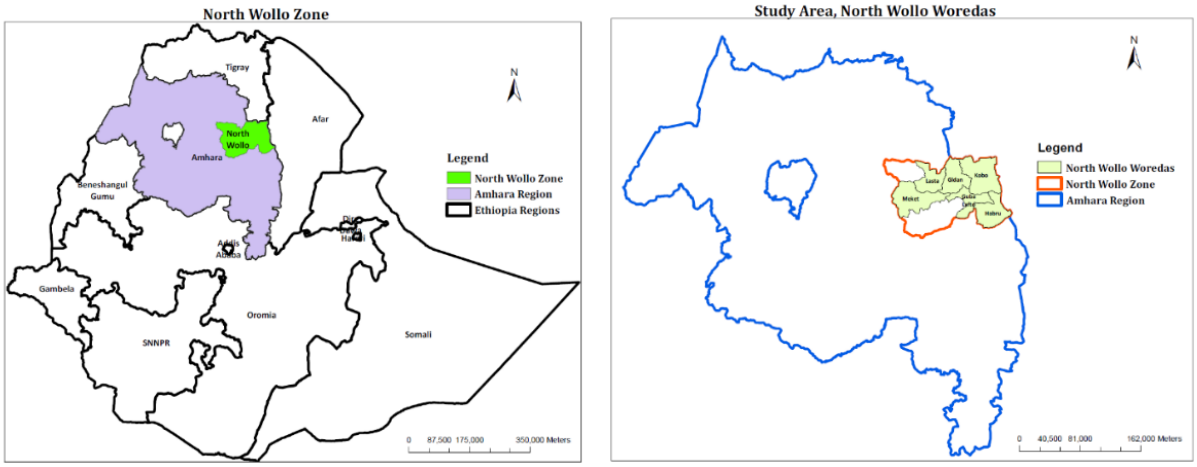

Figure 8: North Wollo Zone and Woredas

All of the places I visited are rural communities who earn their livelihood with subsistence farming. These communities have the minimum basic infrastructure or amenities. In most parts there are no asphalted roads, electricity, mobile phone connection, clean water supply, or private service centers such as clinics or schools. In addition, access to public transportation is

[1] A Woreda is an administrative division of Ethiopia that is equivalent to district. It is composed of a number of Kebeles (wards or neighborhood associations), which is the smallest administrative unit.

restricted to market days, which is once or twice a week. Thus, walking for a couple of hours to get to places is the norm. people use donkeys and camels to transport goods.

Figure 9: Sorghum harvest and the mountains of Kobo Woreda

With construction of new roads, evolving village towns now have horse carriages, bajaj taxis and minibuses. However, the further one goes from the major road, places become less and less accessible via any kind of vehicle. The rugged topography also adds to this complication. The major source of energy for cooking is fire woods, dry cow dung, charcoal and kerosene. Candles and kerosene lights are used at night.

In terms of health care, every place has health posts with at least one [usually two] health extension worker providing community based health promotion and risk prevention services, including prenatal and postnatal care. However, this health posts are not always open since health extension workers are expected to do home visits and take part at various trainings and meetings. The health center is usually located in the nearest town which could be quite a distance ranging from 1hour to 8 hours depending on how far they are from the major road.

As discussed in the methodology session, community based volunteers, religious leaders, and community elders who have relationships with people in the neighborhood, were used as gatekeepers. I was introduced to potential research participants by the gatekeepers. Gatekeepers have close respectful relationships with community members which may pressure potential research participants to be involved in the research. Therefore, to avoid the pressure and ensure voluntary participation in the research, gatekeepers were kindly requested to leave after introducing me to potential research participants. During the first meetings, I assured potential participants that everything we discuss is confidential and no information will be shared with gatekeepers including their decision to participate or not. I also confirmed that they can withdraw from the research anytime without facing any consequences. I also used public transportation to get to different places to meet with gatekeepers and research participants because I do not want research participants to associate me with just PADet which has a significant presence in most part of North Wollo.

I also used the first one-to-one meetings as an informal introductory session where I tried to introduce myself and get to know my potential research participants without taking notes or recording. I tried to build rapport and ensure voluntary participation in the research and get permission to take notes and record the interview. During this one-to- one informal introductory session, two potential research participants refused to take part in the research because they do not want their voice recorded. With the 27 potential participants who consented to be part of the research, I rescheduled a [formal] interview day at their time and place of convenience. The informal introductory sessions fostered a conducive environment for the interview since it created an opportunity for me as well as research participants to get to know each other. Hence, interviews were generally quite deep.

B. Research Participants' Background

The research participants were women community members with different socioeconomic and educational backgrounds. A couple of them have BSC or BA degrees, some finished high school [grade 10 in Ethiopian curriculum], some only went up to grade 6 or 7, some can only read and write without 'formal' education, and others cannot read or write. They also have different livelihood or professional backgrounds including: farmers, health extension workers, community based volunteers, small business owners, traditional birth attendants, Women Affairs Office representative, and NGO program coordinators. To ensure confidentiality of participants, I have replaced the names of my research participants with pseudo names. The places I visited during this interview include: Libsom, May Teklo, Girana in Habru Woreda; Ahun Tegene, Tesfa Giorgis and Hara in Guba Lafto; Walka in Meket; Beklo Manekia in Gidan; Kalim, Mito, Afaf in Kobo; and Lalibella in Lasta Woreda. Interviews were carried out at home, under the shadow of a tree, in an office or empty class rooms or backyards depending on research participants' convenience. The table 1 summarize their demographic background along with their pseudonyms, and the place of the interview.

Figure 10. Open market in Kobo

Figure 11: mountains/farm land in the village of Tesfagiorgis

Table 1 Background of Research Participants

Background of Research Participants								
Pseudo Name	**Interview Place**	**Interview Setting**	**Age**	**Marital Status**	**# Of Children**		**Educational Status**	**Livelihood/remark**
					M	**F**		
Hizbe	Mayteklo-Habru	under the shade of a tree	21	Single	0	0	10	Community Based volunteer
Selam	libsom, Habru woreda	under the shade of a tree	29	Married	3	3	Read and write	Community member
Shewa	libsom, Habru woreda	at home, drinking tea	40	Married	3	3	7th grade	Community member
Emama Fate	libsom, Habru woreda	home, at the backyard	65	Widowed	2	3	uneducated	Community member Had 14 children- 9 deceased
Zere	Ahuntegegne	in a backyard	27	Married	1	2	no formal education	Community member
Desta	Ahuntegegne	At home	22	Married	1	1	10th	Community member
Mente	kalim- Raya Kobo	in a classroom	29	Married	1	1	6^{th}	Community member
Mulu	Mito- Raya kobo	under the shade of a tree	38	Married	3	1	Read and write	Community member
Meseret	Gidan	Office/kebele	25		1		no formal education	Community member
Fenta	Meket, Walka	Home	20	Divorced	0	0	no formal education	Community member/ arranged marriage
Emama Fate	Hara Gubalafto	Home	67	divorced	3	1	no formal education	Community member
Emama Halima	Girana	at home	45	Married	3	2	Read and write	Community member- had 9 kids, 4 deceased
Tayech	Girana	at home, verenda	22	Married	2	0	6th	Community member- was in Saudi
Sindu	Kobo- Raya Kobo	Home	52	Married	2	2	Read and write	Community member- was TBA
Emama Tenagne	Gubalafto	Home	60	Widowed	3		Read and write	Community member- was TBA

Debre	Tesfa Giorgis-Gubalafto	HEW's office	24	Married	1	0	10 + 1	HEW
Mistre	Kalim-Raya Kobo	under the shade of a tree	27	Married	1		10+1	HEW
Tsige	Mito- Raya kobo	under the shade of a tree	28	Married	0	1	10 +1	HEW
Kinde	Gidan	Home	29	Single	1	0	10+1	HEW
Hirut	Girana	HEW's office	35	Married			10+1	HEWs
Birhan	Gubalafto	Home	31	Single	1	0	10	office clerk
Serke	libsom, Habru woreda	at home, drinking tea	38	Separated	3	1	no formal education	own business-barber- was in Saudi
Ayda	Gubalafto	Home	28	Married	1	3	10	own business-kiosk
Alem	Raya Kobo	home, cooking	50	Single	0	0	Diploma, MGT	project coordinator, PADET
Bethel	Lasta Lalibela	Office	29	Married	1	1	nursing BSC	project coordinator, PADET
Million	Kobo- Raya Kobo	office-PADET	29	Complicated	2	0	Read and write	Small business-traditional liquor
Aynalem	Kobo- Raya Kobo	office-Women Affairs	48	Married	1	2	BA MGT	women affairs head

C. Motherhood: Definitions and Concepts

1. Who is a Mother?

All research participants identified a mother as a woman, who gave birth to a child, or raised a child, or helped raise a child. One participant, Hirut, a health extension worker and mother of a girl, said that "Mothers are women in general, because we give birth. By natural virtue, women tend to care and relate to children better than men."

> እናት እንግዲህ ሁላችንም ሴቶች - ሴቶች በአጠቃላይ! ምክንያቱም እንወልዳለን፣ የናትነት ተፈጥሮ በራሱ ለልጆች የምናደርገው እንክብካቤ ከወንዶች በተሻለ ሁኔታ ለእናት ተሰጥቷል ከልጆቿ ጋር ካላት ግንኙትና ቀረቤታ አንጻር ማለት ነው።

The instinct of motherhood was further explained by another research participant, Alem, who is 50 years old, never married, has BA in management, and raised 6 children [her nieces and nephews], said that

> When I developed an affection to motherhood, I started observing birds; how they feed their hatchlings, and other animals protecting their babies. It is hard to explain motherhood. Mothers are unique. You cannot compensate a mother with any amount of money. Starting with pregnancy, then birthing, nurturing children, a mother copes all the challenges. She is a survivor. Children can never payback their mother's debts. For me my mother is special. But I didn't know it until I get older, and started raising orphaned children *[her niece and nephews, since their parents died due to AIDS]*. I realized that no matter what I do for these children, I can never replace their mothers love.

> የእናትነት ፍቅሩ እያደረሰብኝ ሲመጣ ወፎችን ሀሉ አያለሁ ምግብ አስክሰው ከአፋቸው ሲሰጧቸው እና ነበእንስሳቱ ጀምር እናት የሚገልፅ አይደለም ስታይው ስታወዳድሪው ከባድ ነው እናት የተለየች ናት በምንም ዋጋ ሳትሰጫት ልትከፍያት አትችይም ከእርግዝናው እስከ ውልደቱ፣ እስከማሳደጉ ያለውን ጫና ተቁማ መቆየቷ! ልጅ እኮ የናቱን ውለታ በፍፁም አይከፍልም እናት ለኔ ልዩ ነች ግ መጀመሪያ አላወኩላትም አሁን እድሜዬ ሲጨምር በተለይ እናት የመተባውን ልጆች ሳሳድግ ምንም በማር ፈትፍተሸ ብታበይ ምንም ብታደርጊ የእናትን ፍቅር አይተካም።

Then, Alem showed me moving pictures of 'mothers' love'—mothers taking care of their children, birds taking care of their hatchlings, and other animals taking care of their babies [some of the pictures are attached in an appendix] from her picture collections.

Sinidu, who was a traditional birth attendant, explained a mother saying: "A mother is just a mother. There is no comparision to her. She is above everyone in caring for her children. I cannot say enough about motherhood." ወይ እናትማ እናት ናት ወደር የላትም ላላት ከሁሉ በላይ እናት ናት። ለልጆቿ እንከብካቤ፣ ለልጆቿ ጤና ከማንም በላይ ሆና የምትገኝ እናት ናት። እናትነት ቢገልጽ ቢገልፅ አያልቅም።

Another research participant, Hizbe, confirmed the above points saying:

> I consider my mother as the essence of my life. She cares and desires the best for me. She also works so hard to make me happy and I also work hard to make her happy. She is above and beyond everyone in my life. I love her more than myself. Mothers are so essential for children.
> እናት ማለት እንግዲህ እንደ ህይወቴ ነው የማያት፣ እናት ማለት ለኔ የምትጓጓልኝ አንድ ነገር ብሆን የምትጸጸትልኝ በቃ ከሁሉም በላይ እናቴ ለኔ ብዙ ጥረት ታደርግልኛለች እኔም ጥረት አደርግላታሁ። ከማንም በላይ እናቴ ናት ከራሴ በላይ አብልጬ የምወዳት እናቴ ናት።

Research participants also identified mothers as building blocks of a family and society since they are socially and culturally responsible for nurturing, even procreating children. Birhan explained this notion saying "mothers are the one who create the next generation- whether she is poor and struggling, or rich, she produces children who would be presidents and doctors." "ሃገር ተረካቢ ዜጋ የምታፈራ እናት ነች አክንባሎም ሸጠች፣ ጎመን ቀንጥሳ ሸጠች፣ እንጀራም ጋረች ፕሬዘዳነትም የሆነውን ዶ/ርም የሆነውን ልጅ ሁሉ ያፈራች ይቺ ምስኪን እናት ነች።"

Even if it takes both women and men to reproduce, the role of procreation is socially and culturally assumed to be women's responsibility. In rural areas like North Wollo where there is no medical facility that provides fertility test, infertility is assumed women's problem. If couples fail to have a child, the wife is blamed and stigmatized; while the man can marry another woman to get children. These perceptions leave a woman with psychosocial and economic damage that is related to infertility, divorce and/or separation. Explaining the procreative role of women, Fenta who was forced to marry at 16, told me that she used Depo-Provera, a birth control shot, without the knowledge of her husband as well as his/her family, because she decided not to have a child until her economic condition improves. After a couple of years, the family thought she is infertile thus she eventually left that marriage. After leaving her marriage she could not easily go back to her family because of the stigma attached to divorce/separation thus, she started petty trading, selling vegetables and charcoal, to sustain herself.

A couple of my research participants strongly believed motherhood should be attached to giving birth. They argued that it is hard to understand the pain, happiness and love a mother experience during birth unless one goes through the process. Serke said "of course a mother is the one who give birth" and she asks "how can someone know about motherhood without experiencing pregnancy and birth?"

"እህ! የወለደች እንጂ እናትማ የምትባለው :: እንግዲያ ያልወለደማ እንዴት ያውቀዋል?"

Others strongly believed that a woman does not need to give birth to a child to be a mother as long as she helps raise children. Many participants mentioned that if a woman cannot give birth due to various reasons, the tradition allows her to be *abelije* (Godmother) and help raise her friends' children, or raise children who are her relatives or kin [niece, nephews, cousins, etc]. Therefore, as long as she helps raise a child and fulfills her duty as a mother by providing the child [or children] with basic necessities, stay attached to the child, sharing and contributing to social events including birthdays, weddings, funerals, she is a mother.

Emama Fate described this notion of motherhood saying

> Even if she doesn't give birth she is a mother. As long as she is reliable and caring she will be called a mother. Her provision to children enables her to be called 'mother'. If I raised a child and I wed[2] him [including all the things in between] he calls me 'Enate, enate' (mom, mom), even if I did not give birth to him. The duty of motherhood is more important.

> እናትማ እናት ናት፤ ባትወልድም ሁነኝ ሆና ተቆርቋል ከሆነች እናት ትባላለች በእናት ስም ትሰማለች ያቅመም እናት ያስብለዋል። አሁን አሳድጌ ካደረኩ ከኪልኩት እናቴ እናቴ ይለኛል ባልወልደውም ጥቅም አለው ቅዋው እናትነት::

[2] In North Wollo weddings are important milestones in a lifecycle of an individual; just like birth and death. Wedding is considered the flipside of death- there is a proverb that goes as "weddings and funerals are alike" "ሠርግና ሞት አንድ ነው" to show the sociocultural significance of weddings and funerals.

Another participant, Hirut, also clarified this notion pronouncing “for example there are women who cannot give birth. However, they know about children. Even if they didn’t give birth, they raise them. They [women who are infertile] raise children better since they aspire to have a child”. መሀን ሴት አለች ለምሳሌ መሀንም ብትሆን ግን የልጅን ነገር ታውቃለች እሷ ባትወልድም የሌሎች ልጆችን የምታሳድግ እናተ አለች። እንደውም እኛ ከወለድነው በተሻለ መልኩ እነሱ የልጅ ጉጉት ስላላቸው -- ልጆችን የሚንባከቡት እነሱ ናቸው።

Another participant, Alem backed the above argument saying:

> I don’t think that a woman has to give birth to children to be called a mother. I didn’t give birth to a child but I raised six children. I can even say that I raised these children better than a woman who give birth to a child. When I examine their discipline and educational performance they are better than other children in the community. There are mothers who don’t provide the necessary care to their children even if they give birth to them. For some children the love and care they get from their neighbor could be better than the love and care they receive from their parents. Thus, it all depends on the mothers’ personality. If you see what a child gets during pregnancy, it is similar for all children. But things start to change once the baby is born.

Alem continued to explain,

> If you think of children who are in orphanage it is overwhelming. I had a chance to visit an orphanage that provides care and support for children born with HIV/AIDS. The nanny who provides care for these children was an older lady and everyone can tell the love and deep connection she has with the children. Thus, this lady is a mother. The major thing is raising children properly.
>
> አላስብም እኔ አሁን አልወለድኩም ቢያንስ ከ6 ያላነሰ ልጅ አሳድጊያለሁ ሳሳድጋቸው ከወለደችው እናት የተሻለ አድርጌ አሳድጊያለሁ ማለት እችላለሁ በስነምግባር በት/ትም በጸባይም ከሌሎች ከማየው አንጻር የተሸሉ ናቸው ወልደውም ለልጆቻቸው እንክብካቤ የማያደርጉ አሉ አንዳንዱ ደግሞ ወላጅ ከሚሰጣቸው ፍቅር ይልቅ የጎረቤታቸው የሚሻልበት ሁኔታ አለ እንደናቶች ባህሪ ይለያያል ነገር ግን እና የምትሰጠው አገልግሎት ነው ሊለያይ የሚችለው ከጽንሰት እስከ ውልደት ያለው ግን ለሁሉ አንድ ነው ማሳደጊያ ውስጥ ያው ህፃናትን ስታዩ ልብ ይነካል አንድ ግዜ ኤች አይቪ ጋር የተወለዱ ህጻናት የሚያደጉበት ሄጄ ነበር ህፃናቶች የምትጠብቀውን ሴት በጣም ሰፍ ብለው ነው የሚወዱት የነበረው እኛ ሴትዮም ልጆቹን እያዩ በተለይ ሲታመም ያለቅሳሉ እሳቸው እናት ናቸው:: ስለዚህ በአግባቡ ተንከባክቦ ማሳደጉ ትልቅ ነገር ነው።

In addition to women going through pregnancy and birthing, the responses placed the role of nurturing children at the center of motherhood, expanding this notion to include women who raised children who are related to them (grandmothers, aunts, cousins), neighbors and friends who raised children that are related to them traditionally (*abelij* – Godmothers), and even nannies who raise children in orphanages.

Mothers are also considered to be disciplinarians. Thus, research participants associate female teachers with mothers. For teachers, her students are like her children. She helps them with their academic endeavor as well as in building their character – just like mothers, she can punish students and not be blamed. Hizbe, who has no child, single, and a community based volunteer, said "Teachers have better understanding and knowledge than their students. Thus, if they have children, they discipline students like their children, but if they don't have children; their students are like their own children. She guides them[students] in knowledge and discipline". "ያው ከልጆች የተሻለ እውቀት ስላላቸው ግንዛቤያቸው ከፍተኛ ስለሆነ እነሱ ግን ለታናናሾቻቸው ያው ወልደውም ከሆ እንደልጆቻቸው አይተው ይረጋሉ፤ መምህርም ከሆነ ተማሪዎቿ ልጆቿ ማለት ናቸው እውቀት ታስገዛቸዋለች። እንደናት ትሆናለች።"

a. <u>Other characteristics of motherhood</u>

In *North Wollo* age plays a significant role in the construction of motherhood. If a woman is older, whether she raised children or not, the community address her as 'emama'- mother. 'Emama' [mother] is used to show respect to older women. You might have observed that I used Emama to address some of my research participants, even if the names are replaced with pseudo names. I used this prefix to show respect. Explaining this theme, Zere, said "if they are older, those who don't have children are also addressed as mothers". ልጆች የሌላቸውም እናት

ይባላሉ ወልደው ከጨረሹና እድሜያቸው ከገፋ:: Desta also confirmed this argument saying "we address older women as mothers to show our respect" "በእድሜ ገፋ ያሉ እናት ይባላሉ ያው እነሱን ለማክበር ስንል እናት የምንላቸው"

Traditional birth attendants (TBAs) are also considered mothers to children they help deliver. Emama Tenagne explained her social position as a TBA saying "I am a mother of plenty; and a sister to many mothers". - እኔ የብዙ ልጆች እናት ነኝ የብዙ እናቶች እህት ነኝ። Another participant, Sindu, who was a TBA for the past 10 years also explained that neighbors and family members tend to address children whom she helped deliver as her children.

In addition, being affiliated with religion or being spiritual is another identifier to the role of motherhood. Nuns [those affiliated to the Ethiopian Orthodox Church] and spiritual women[3] are considered and addressed as mothers since their prayers and blessings are believed to transcend to the community, the nations and even the world. Spirituality being the center of peoples' life in North Wollo, there is a tremendous respect for spiritual mothers. These women are considered as spiritual bearers of the community and intermediary between the spiritual and physical world.

2. Construction of Motherhood

Examining the responses of the research participants the performative notion of motherhood which compels women to be care givers and nurtures is clearly observed. Similar to Butler's (1994) representation of gender as 'performance', research participants characterized motherhood through the act of raising and nurturing children. Butler (1994) highlighted that

[3] I used spiritual women to refer to *Dubertis,* women who are leaders of traditional spirituality, in North Wollo. They perform and lead spiritual rituals during birthing and natural calamities [such as drought and flood]; and mediate and reconcile conflicts – blood-raids between groups.

“there is no gender identity behind the expressions of gender; that identity is performatively constituted by the very ‘expressions’ that are said to be its results” (p. 25). Correspondingly, for research participants, motherhood is expressed through the act of mothering than giving birth to a child. This performativist definition of motherhood has also shaped the social status of women in the community. Through raising children women are given a better social position and are assumed to fulfil their social and cultural role as a woman.

a. Motherhood as a privilege

Most participants agreed that motherhood comes with responsibility as well as privilege within the community. Some even argued that Motherhood is so precious and a blessing. Birhan said that “even if I realized it after I became a mother; I think motherhood is a blessing” እናትነት በጣም ጥሩ ነገር መቼም የማታገኚው ፀጋ ብዬ ነው የማስበው ::

Reflecting on how having children is valued in the community, Alem said

> In this community, having a child is a place of privilege. And, having more children is always preferred. Children create more family and kinship bonds through marriage. The bonds through marriage create more social respect. Thus, the more children you have, the more respected and privileged you would be. However, if a woman has one child or didn’t have a child at all, she would be stigmatized and considered selfish.

> እንደ አካባቢው ወላድ መሆን ከፍተኛ ክብር አለው:: ብዙ መውለድ ይመረጣል:: ብዙ ከወለዱ ብዙ ቤተሰባዊ ትስስር ይፈጥራሉ “በየበሩ ዘመድ አብዛ” ይባላል:: እዚም አማች መጣላት እዚህም አማች መጣላት ይባላል:: አምቻዎቹ ደሞ የሚሰጡት ክብር አለ:: በአካባቢው ተቀባይነቱ ክብሩ የጎላ ነው፡ ፡ አንድ ከወለደች ወይ ልጅ ከሌላት ምን ይቺ ነጠላ ካለሆደ ምን ታውቃለች ነው የሚባለው::

Motherhood as a responsibility entailing selfless love and sacrifice

Research participants emphasized that Motherhood is a massive responsibility! Despite their socioeconomic status, taking care of children is a unifying role for mothers. The role and responsibility of a mother to her child/children continues from conception to death. Research

participants confirmed that their own mothers were responsible to care for them and their grandchildren during postpartum and after.

Providing children with basic needs: feeding, cleaning, clothing and sending them to school was identified as a major role of mothers. Living in rural settings on very limited resources, these roles can be very challenging, especially sending children to school is taxing to the family. Children's labor contribution is required to fulfil the basic needs of the family as they help in the household chores – fetching water, cleaning and cooking. Children also keep the herd, feed cattle, and help at the farm.

Hizbe discussed how the rural livelihood influences children's to access to education and success in the education system as follows:

> Rural livelihood is demanding. Students wouldn't even remember where they placed their notebook when they return home from school since they have work waiting for them. Parents also expect their children to help when they get home. Most parents do not focus on their children's schooling or their progress. Even if the student is really good, his/her academic achievement declines through time. That is what I witnessed living in this community. Sanitation is also a huge problem in rural settings and the quality of life is poor.
> የገጠር ኑሮ እንግዲህ በአብዛኛው ሞጥፎ ነው። ብዙ እንግልት አለው። ልጆች እንክብካቤ አያገኙም ተማሪዎች እራሱ የገጠርና የከተማው በጣም ይለያያል አሁን የገጠር ተማሪ ልብሱን ከ8 ቀን 1 የሚያጥብ አይገኝም ከስንት አንድ ነው። የገጠር ኑሮ ስራ ይበዛል ለግብረና ስለሚተዳደር ሰው ከት/ት ሲመለሱ ተማሪዎች ደብተራቸውን የሚያኖሩበትን አያውቁትም በፍጥነት ለስራ ነው የሚገቡት ቤተሰብም ልጆቹን ነው አይን አይነት የሚያይ ቶሎ መጥተውልን ከብቶችንን አይተውልን፣ ውሃ አጠጥተውልን ነው እንጂ ምን ተማሩ የሚል የለም። የቤት ስራ ካላቸው ብሎ የሚያስብ ብዙ ወላጅ የለም። ለምሳሌ ጎበዝ ተማሪ ከሂነም እየሰነፈ ነው የሚሄደው ገጠር ኑሮ በብዙ የማውቀው ጉዳቱን ነው፤ ንጽህናም በአብዛኛው አይጠበቅም እንግልት አለ።

Research participants explained motherhood as selfless love and sacrifice. Taking about motherhood was at times very emotional for research participants since it unfolded a lot of hurt and abuse their mothers [or themselves as mothers] had to endure to bring up their children. Mothers were praised for enduring the hurtful environment and staying around for the sake of

their children. All research participants believed that Motherhood requires passing through a lot of physical, psychosocial, and economic challenges during the time of pregnancy, birth and labor, postpartum, breast feeding, child rearing, … etc. Mothers suffer from psychosocial and economic stress when a child gets sick. Moreover, Mothers may experience abuse, including domestic violence to create the 'socially acceptable' environment for their children. I did not assess issues related to domestic violence in these interviews since it is beyond the scope of this study, however, it is an issue that has been raised by many interview participants as part of mothers' duty or as a challenge she passes through to raise her children 'right'.

One mother, Birhan, with tears in her eyes, said that having a child involves a lot of work. Mistre said: "Motherhood is very challenging. Children would get sick and the mother will be stressed. Even pregnancy has its own 'natural' pain. You can't sit or sleep as you like. After giving birth, you have to give love; there is also the challenge of life, which makes it very difficult". "እናትነት በጣም ከባድ ነው ከአስተዳደግ ጀምሮ የተማሩ ሲታመም ትጨነቂያለሽ ካነብሰ-ጡርነት ጀምሮ እራሱ ነፍሰ ጡር የራሱ የሆነ የተፈጥሮ ህመም ይኖረዋል:- እንደፈለግሽ አትተኚም እንደፈለግሽ አትቀመጪም ብዙ ነገር አለው ከተወለደ በኋላም ሁሉ ነገር አለ:- ፍቅር መስጠት አለ ኑሮ አለ ስለዚህ ማዜውም ሁሉም በጣም ከባድ ነው!"

Emama Fate confirmed this notion saying: "Motherhood is very difficult and mysterious like the sky" "የሠማይ ያህል ነው እናትነት :- ከባድ ነው:- ያንገላታል ::" Mulu, a mother of four, said "a mother is the one who gives birth and raises children. There is a lot to motherhood. Life has a lot of challenges. Mother puts her children first, feeding them before herself". "እናት እንግዲህ ወልዳ የምታሳድግ ናት የናት ጉዳዩ ብዙ ነው እንግዲህ ተነግሮ አያልቅም። የኑሮ ሁኔታ ስንት ጉድ አለው እንዳይርባቸው ጡጧን ውላ ለልጆቿ እነሱን አብልታ፣ የኔ ይቅር ብላ አብልታ ብዙ ነው ጉዳዩ ::" Bethel

supplemented Mulu's point saying: "A mother has a lot of responsibility, she carries a lot of burden for her family and children. She is the pillar of a family*". "*እናት በጣም ብዙ ሃላፊነት ያለባት፣ ብዙ ጫና የምትሸከም፣ ለልጆቿ ደግሞ ምርጥ ሴት ናት:: የቤተሰብ ምሰሶ ናት እናት በአጠቃላይ። ለልጆች፣ ለቤተሰብ ስለ ብዙ የምትሸከመው ኃላፊነት አለባት።" Tayech also mentioned that "Motherhood is a sacrifice for the sake of children. A mother is one and only. She cannot be replaced. " እናትነትማ ለልጇ መሳዳት፤ ለልጆች በሚፈገለው መልኩ መንከባከብ- እናት ደግሞ አንጀት ነች፤ እናት በጣም አስፈላጊ ነው ::"

Zere talked about her role as a mother saying, "For my kids! I rather leave my needs unattended. I take care of them [her children] very well. I will buy them clothes and stationaries. That is how our mother raised us: sacrificing her needs." "እኔማ ልጆቼ የኔ ይቀራል እንጂ ልጆቼን በጥሞና እይዛለሁ እናት ስባል ልጆቼን ልብስ አልብሼ ልጄቼን ደብተር ገዝቼ የፈለጉትን ማለት ነው እናት ሲባል፤ እናታችንም ስታሳድገን እንደዛ ነው ::"

Million, who married at the age of 14, separated with her childhood husband, currently single and a mother of two, said "a Mother is like breath. There is no one who is patient like a mother. Mothers love never fades. She scarifies herself and lives for her children. Personally I don't want my child to face the challenges I faced as a child so I work so hard." "እናት ለኛ ህይወት ናት እንደእናት ቻይና ታጋሽ የለም: የናትነት ፍቅሩ የጨመረ እንጂ አይቀንስም:: እናት ህይወት ናት ለልጇቿ ተቸግራ ይህን ይህን ባረገው ብላ ነው የምትኖረው ዛሬ መቼም ልጆቼ ይህን ጥቤ ብሄድ እያልን ነው የምፈልጋቸው ያለነው ልጇ እንደእኔ እንዳይሆን ለውጥ ለማምጣት ነው።"

Emama Halima explained the responsibility and challenges of motherhood as:

> Motherhood requires a lot of sacrifice: feeding children, going through a lot of challenges. I raised this boy [showing me the little boy who was taking a nap next

to us] because I don't want my daughter to go through the hassle. [Her daughter works in Jidah, Saudi Arabia]. I also refused to sell the land because they [her children] need a place. I am telling you, raising children isn't easy, it is a lot of work.
እናትነትማ ሲርበው አብልቶ፣ ተቸግሮ ተጠምቶ ጠቁሮ ከስቶ እናትነው አሁን ይህን በሰው የምታይው ልጅ እንዳትንገላታ ልጇን ወስጄ አሳምሬ አሳድጌ ልጄን ልጆች እንዳይቸግሩብኝ በታይቱን አልሰጥም ብዬ ይዤ ነው እንደዚህ ነው እናት እንደዚህ ብትሆኑም አሁን መከራ አይታችሁ መከራ ታይቶ ነው የምትማሩት። ዝም ብሎ አልተወለደም ልጅ ነው የምልሽ ስራ አለው

b. <u>Motherhood: unconditional love; a mother: one and only- irreplaceable</u>

The other important component that often surface the discussion of motherhood is the love attached to motherhood. Participants stressed that mothers' love is unconditional; it entails the ability to give and receive without any preconditions. Participants also emphasized that Mothers deeds cannot be compensated in anyway except through giving pure love. A mother is one and only, someone who can never be replaced!

Explaining her experience as a mother raising her niece and nephews after they lost their parents due to HIV, Alem said that "Nothing replaces mother's love. Those children will always miss their mother" "በማር ፈትፍተሽ ብታበይ ምንም ብታደርጊ የእናትን ፍቅር አይተካም።"
Desta, 22 years old, married and a mother of 4 months old boy, said, "when I gave birth to my boy my mother took care of me. She is the one who helps me with my baby, she does everything for me even if I am an adult now. I can't explain motherhood. I think it is a sincere love". "አሁን ይህን ስወልድ እናቴ ናት የምትንከባከበኝ ልጅ የምትይዝልኝ ሁሉን ነገር የምታደርግልኝ ስለዚህ እናትነት ብቻ በኔ በአንደበት ሊገለፅ የማይችል ትልቅ ፍቅር ያለው ነገር ነው የሚመስለኝ::" Selam, married and a mother of 3, expressed the love attached to motherhood as reciprocal, saying "My mother loves me so much and I love her back and care for her. I love my mother. I care for her deeply like she cares for me". " እናትማ በደንብ ለኔ ፍቅር ሲኖራት እኔም በቃ በልጅነቴ በጣም አድርጌ አፈቅራትና

እይታለሁ እናቴን እወዳታለሁ ልክ ለኔ ፍቅር አድርጋ እንደምታደርግልኝ እኔም እናቴን እይዛታለሁ ::“ Then, Selam discussed her role as a mother and how the love she gets from her children helped her understand motherhood as:

> I knew nothing when I got married. My parents forced me to marry and drop out of school. However, after I give birth and start getting love from my children, I understood motherhood. I never realized that my mother went through all the challenges until I became a mother myself. So motherhood is providing for children.
> ከበፊት ከትምህርት አቋርጠው ትዳር ሲመሰርቱልኝ አላውቅም፣ ግን አንድ ከወለድኩ በኋላ እናትነቴን ሳውቀው ልጄን ወልጄ ፍቅር ሳገኝ ከልጄ እናት ሆንኩኝ። ልጅ ሆኜ እናቴ ይህም ማድርጓን አላውቅም ትምህርትም የለኝም አሁን ግን ሲገባኝ ከልጆቼ ፍቅር ሳገኝ እናት መሆኔን የምገልፀው ልጅ ወልጄ ለልጆቼ ዳደርግ ነው።

Emama Tenagne, a mother of 5 and a traditional birth attendant for more than 34 years explained a mother as “one and only” magnifying her importance for her children. She added:

> Mother cannot be reproduced or replicated. For instance, my children have sisters so if something happens they will still have sibs, but if I die, there is no one. A mother is not a joke. Christianity as well as Islam teaches us to respect our mothers. A mother has no substitute.
> እናት አንድ ሆና ነው ያስቸገረች ድጋሚ የላት ፈላጭ የላት ቁራጭ የላት እህት እህት አለ አሁን ልጆቼ እኔ ግን ብጠፋ ማንም የላቸውን እናት ቀልድ አይደለችም። ከክርስቲያንም ሆነ በሙስሊም እናትን አክብር ይላል። መተኪያ የሌላት የምታፈሺው ነገር መተኪያ የለው እናት መተኪያ የለው።

In the same manner, Mente, who dropped out of school after her father died, got married at 15, now 29 and a mother of 2 explained the value of a mother and the notion of motherhood with full of emotion as:

> Motherhood- giving birth after carrying a baby for 9 months, breastfeeding for 3 years; going through labor… there is a lot to motherhood. Women comprehend it when they go through the process themselves. Men may understand it after they have children and start to be conscious about motherhood. Next to God, one can never payback to mothers’ deeds. It is so profound.
> እናትን በጥሩ ሁኔታ ወልዳ ፱ወር ተሸክማ ፫ዓመት አጥብታ የአንዲት ቀኗ ምጥ : ያው የናትን ውለታ ሴቶችም ወልደው ሲያዩት ያውቁታል:: ወንዶችም በልጆቻቸው ሲያዩት የናቶቻቸውን ነገር ሊንከባከቡት ይችላሉ:: ከፈጣሪ በታች የናት ውለታ ተከፍሎ አያልቅም:: በጣም የከብደ ነው::

3. Motherhood Before and After Giving Birth: Participants' Deliberation

The research participants who gave birth to a child and raised children highlighted that their attitude towards motherhood changed the moment they became a mother. For most of them, going through the experience of birthing is the time they started appreciating their mothers better, and understood the level of strength motherhood entails.

Misre discussed this difference saying "before it is a young age and you tend to think about your life. But after you give birth, you start thinking for your children and think of motherhood. You also start questioning, how did my mother raise me? This is the difference". ከመውለድሽ በፊት ወጣትነትም ኖራል ስለራስሽ ህይወት ብቻ ነው የምታስቢው ከወለድሽ በኋላ ግን ስለልጅሽ ማሰብ ትጀምያለሽ እናትነትን ታስቢያለሽ። እናቴ እንዴት ነው እኔን ያሳደገችኝ የሚለው ጥያቄ ወደ አንቺ ይመጣል። ይሄ ልዩነት አለው።

Alem also confirmed

> Motherhood is unique but I realized it now; after my two sisters died leaving 3 and 2 kids respectively. Before I was a Daddy's girl. When I observe my other niece and nephews who has their parents and see the love they get from their parents, I realized how sacred it is. Also I realized how mothers are unique gifts from God after my father passed away. I cannot equate my mother with anything. እናትነት ልዩ ነው ግን እናትነትን ያወቁት አሁን ነው በፊት ለአባቴ ነበር በጣም የማደላው ሁለት እህቶቼ አንዷ 3 ልጅ፣ አንዷ 2 ልጅ ወልደው ነው የሞቱት ከዛ በኋላ ሌሎቹ ለልጆቻቸው የሚሰጡትን ወልደው ነው የሞቱት ከዛ በኋላ ሌሎቹ ለልጆቻቸው የሚሰጡትን ፍቅር ላይ እናት ስሌላቸው እነሱ በጣም ነው የምሳሳው

Bethel added

> My value for motherhood before I gave birth and after is very different. I didn't understand motherhood before. Of course I loved and respected my mother, but after I gave birth, the love I have for my children and the stress I experience makes me think of my mother. It made me realize the hoops my mothers have to pass through to raise us. As difficult as it is, compared to the past, we can argue that it is easier to raise children these days. (Pause). I can't even imagine how difficult it was for her to raise us at that time. She had a lot of burden. I really respect my mother!

ከወለድኩ በፊትና በኃላ በጣም ይለያያል። መጀመሪያ ምንም አይመስለኝም ነበር። በእርግጥ ለእናትሽ የምትሰጪው ፍቅር ክብር አለ- ግን ከወለድኩ በኋላ ለልጆቼ የምሰጠው ፍቅር የምጨነቀው ጭንቀት ሲገባኝ ለካስ እናቴ እንዲህ ትጨነቃለች ምን ያህል ነገር አሳልፋለች ብዬ አስባለሁ ያውም አሁን ከድሮው በጣም የተሸለ ግዜ ነው በዛ ግዜ እኛን ማሳደጓን ሳስበው በጣም ይከብደኛል። ብዙ ጫና ነበረባት። ብዙ ከባድ ነገር አሳልፋ በመምጪ ለኔ የምሰጣት ቦታ በጣም ከባድ ነው።

Zebenay said that after she became a mother herself she realized she should have cared more for her mother and she regrets how she treated her.

I did not think of my mother as something special. I didn't respect her as such. But after I become a mother and see my children I realized I should have cared for her. I realized how difficult motherhood is and how difficult life is. So after passing through the experience, I really respect and sympathize with my mother and father.

አዎን ፊት እናቴን እነደቀላል ነገር አያት ነበር አካባጇም አላያትም ግን ዛሬ ወልጇ የኔን ልጆች ላይ እናቴ ለካ እንደዲህ አርጌሽ ቆይቷል፤ እናቴ በለካ ይህ አስተያየት ሳላድርግልሽ ቆይቷል ዛሬ እናትነት እንዴት ይከብዳል፤ ልጅ ማሳደግ እንዴት ይከብዳል፤ ኑሮ ለካ እንዴት ይከብዳል፤ እያልኩ ለእናት ለአባቴ በጣም አዝናለሁ ዛሬ ኑሬ ላልፈው ማለት ነው።

Debre, who is a health extension worker, confirmed that being a mother urged her to help the community, especially expecting mothers, better. She said "the love I have for mothers is very different now. Before, I didn't care much. When I see pregnant women I didn't think of labor and how difficult it could be. But now, I have sympathy for them. I don't want them to go through pain". "ለናቶች ፍቅር አሁን በጣም የተለየ ነው። ከበፊት ብዙም ይመስለኝም ነበር፤ አርግዘው ሳያቸው ተቸግረው የሚወልዱ አይመስለም ነበር። ግን አሁን በጣም ነው የሚያሳዝኑኝ፤ እንዲታመሙ አልፈልግም እንደራሴ ነው የማስበው።"

D. Perception of Motherhood and Maternal Mortality: Analysis from Visual dialogue

1. Perception of Mothers and Motherhood: Visual Representation

To get a more enriched overview of motherhood, I have asked research participants to represent a mother visually. These visual representations confirmed the narratives that have been

discussed in the above session. Some of my research participants drew a picture and others represented their view using nature [landscapes and trees] or existing structures [house, household utensils] that I photographed. And some used different expressions.

a. Motherhood as "a breath"

After explaining how difficult it is to represent a mother in any manner, Aynalem said "… I consider motherhood as my breath. My mother is like my life. I wouldn't have been here and I wouldn't have been me without her. So she is my breath." "እናቴ ህይወቴ ናት ብዙ አስብኩ አሰብኩ ምንም አላገኘሁም ስለዚህ እናቴ ህይወቴ ናት" Similarly, three more participants represented motherhood as their breath. Unfortunately, I could not visually capture this construct.

b. Motherhood as "a mirror"

Another participant represented motherhood with a mirror. She mentioned "my mother would see and reflect on her past; how things have been for her through me. And, my kids are the same for me; I will see myself and my past through them"

Figure 12: a mirror mounted on a wall: picture from visual dialogue

c. Motherhood as "earth" – "ploughed land"

Four of my research participants represented motherhood as earth and/or ploughed land. Explaining her representation, Ayda said "a Mother is like a ploughed land. The earth yields better harvest if it is ploughed, watered and fertilized well; likewise, a mother can nurture a happy and responsible child if she has access to everything she needs". Another participant, Mestu, said

> a mother is also like earth. The earth welcomes everyone, including animals. We all walk, run, and play on earth. We also dump our garbage and chemicals on earth. But the earth doesn't say anything! It is patient and accommodating, it is always giving—the food we all eat, the air we breathe. Similarly, mother raises her children coping with all the challenges she faces from her children, her partner [husband], and her community. She accommodates everyone and keeps on producing, giving and nurturing.

Figure 13: ploughed land in the community: picture from visual dialoge

d. Mothers as "flowers"

Tsige equated Mothers with flowers. She argued that flowers shine bright and produce seeds which will make the flora. In the same line, Mothers produce and nurture the future generation.

Figure 14: Flower from a tree at a school backyard: pictures from visual dialogue

e. Mother is "like a house, a nation"

Just like a nation that provides a sense of belongingness, Mothers shelter their children and provide a sense of belongingness. Mothers are the anchor of the family. Even after forming your own life, participants argued, you go back to your mother during any life events [happiness, sorrow, festivals, rituals …anything significant].

Figure 15: traditional hut in the villages: a picture from visual dialogue

f. Motherhood as "Warka"

In the same line another participant represented mothers by *Warka,* a big tree with the scientific name *Ficus vasta*. *Warka* is a big tree with numerous branches and large leaves that can be used as a shade. It also has significant cultural value since in different communities mediations are carried out under the shadow of this tree. Its presence magnifies that there is something big beyond human's control. Thus, for Alem, Mente and Bethel, mothers, alike this tree, are shadows to their children protecting them from any adversities as much as they can and beyond. They are also sacred just like the tree- respected and loved by all.

Figure 16: Warka tree near a river: a picture from the visual dialogue

g. Mothers as "pillars"

Participants said that a house will fall without a pillar, and a family will fall apart without a mother.

2. Perception of Maternal Mortality: Visual Representation

Given the sociocultural, emotional and spiritual significance of Mothers in the community, it was very difficult for research participants to reflect on and visually represent

maternal mortality. After several minutes of deliberation, they [research participants] represented maternal mortality as a gloomy moment that is filled with impairment and hopelessness.

Birthan mentioned that thinking of maternal mortality frightens her. She said

> My heart fills with rage and I don't want to give birth since I know mothers die in the hospital while giving birth, giving life. So, why would I be pregnant. It hurts me because I believe she could have been saved. Even if it is hard to save the baby, mothers should be saved in health facilities. It hurts me, because I know many who died while giving birth.
> በጣም ነው የምናደደው በወሊድ ምክያት ሰው ሲሞት በጣም ነው የሚያናድደኝ ነገ እኔ የመውለድ ተስፋዬ ሁሉ እኔጃ ያስፈራኛል እገሌ ትናት ለመውለድ ሄዳ አይደል የሞተችው እን ታድያ ለምን አረግዛለሁ ብለሽ ተስፋ ትቆርጫለሽ ውስጤ በጣም ይነካል መረዳት እየቻልን ሳትረዳ በመቅረቷ ልጃ በይተርፍ እናት መትረፍ ግዴታ ነው በቃ በወሊድ ምክንያ የሞቱ ብዙ ሰዎች ስለማውቅ ነው ውስጤ ይጎዳል

Then, she represented maternal mortality with unexpected flood. She explained this notion saying *" when it is raining you assume it will be over soon. You will never expect it to turn into flood that takes away everything. Hence, maternal mortality is like flood for me." "*እኔ የእናትን ሞት እንዳድንገተኛ ጎርፍ ነው የማሰበው ሳታስቢው ዝናብ እየዘነበ ነው ያባራል ብለሽ ነው እንጂ የምታስቢው ጎርፍ ሆኖ ሰው ይወስዳል ብለሽ አይታይም ስለዚህ እንደድንገተኛ ጎርፍ ነው የናትን ሞት የማስበው እኔ"

Figure 17: flooding river: a picture from visual dialogue

For Meseret maternal death is gloomy. She said “if a child dies, another one can be born, but if a mother died it is done. She cannot be born or replaced. So for me maternal death is sorrow; moment of darkness. It is all dark- from the head band, the scarf, the dress- everything!” “የእናት ሞት መራር ሃዘን ነው ልጅ ቢሞት ልጅ ይወለዳል እናት ብትሞት ግን አለቁ አትወለድም አትተካም እናለኔ የእናት ሞት ማቅ ነው የመከራ ልብስ ነው ማቅ ጥቁር ልብስ ነው ሻሹም፣ ነጠላውም ቀሚሱም ሁሉም ጥቁር ነው”

Bethel also added maternal mortality for her is a complete darkness. “When you cut a big tree everything goes down with it [including the birds nest]. Maternal death is like demolishing a house. Children and family will be dismantled.” “የናት ሞት ለኔ ጨለማ ነው በጣም ከባድ ነው አንድ ዛፍ ግንዱ ሲቆረጥ አስቢው ብዙ ነገር ነው አብሮ የሚወድቀው ቤት የማፍሰስ ያህል ነው የናት ሞት ልጅ ይበተናል፤ ቤተሰብ ይበተናል።”

Figure 18: Darkness: picture from visual dialogue

Figure 19: Charcoal: picture from visual dialogue

Sinidu added “nobody escapes from death. But mother’s death during birth is woeful. It is like charcoal. Charcoal can be helpful, but it is always dark. Isn’t it a pity that she won’t hold and

kiss her baby? It is also a regret for the new baby if it survives." " የናቶች ሞት ከፍተኛ ሐዘን ነው። ከሞት በሚቀር የለም ግን በወሊድ ወቅት ያለ ሞት በጣም ያሳዝናል። ልቅሶ የሁሉም ልቅሶ ነው ግን የእናት መራር ነው። ከሰል ማለት ነው። ያው ከሰል አገልግሎት ይሰጣል ግን ጥቁር ነው ሁሌም ጨለማ ነው።"

Moreover, several reseach participants represented maternal mortality with falling tree, or a dry wood that has no life. Hizbe equated maternal mortality with a broken *mitad* – injera baking appliance. *Mitad* is a valued appliance in any household since it is used to cook the day to day food for the family, representing the nurturing role of a mother. Broken *mitad* represent lack of sustenance.

Figure 20:fallen tree: a picture from the visual dialoge

Figure 21: broken mitad: picture from visual dialogue

Fenta represented maternal death with burning fire, something that cannot be forgotten, igniting in various circumstances. "የእናት ሞት ለኔ እሳት ነው :- እሳቴ እሳቴ የእናት ነገር ፀፀቴ::"

Figure 22: burning fire: picture from visual dialogue

For Aynalem maternal mortality is very daring even to think about. She represented it with a steep mountain that is scary even to watch let alone to climb. “የተራራ ያክል ነው የከበደኝ”

Figure 23: the mountain: picture from visual dialogue

Examining the responses of research participants, we can infer that motherhood in *North Wollo* is socially constructed through providing sociocultural significance to raising children as part of fulfilling communal expectations of a woman. Motherhood is much more than giving birth to children. It is a broader notion that is centered on women’s role as a caretaker and nurture of children—the future. Motherhood is also sacred and a place of privilege for women. It also entails coping with socioeconomic challenges; providing children with their physical, emotional and spiritual needs, and muddling through domestic abuse.

The nurturing role mothers and the sacredness of motherhood have made maternal mortality ominous and a place of hopelessness to the family members, close friends, and neighbors. Taking about maternal mortality was also emotionally difficult for research participants.

E. Rituals and Traditions during Pregnancy, Birthing, and the 40 Days After Birth

Pregnancy and birthing are accompanied by a lot of rituals and traditions in North Wollo. The family prepares all the necessary food ingredients: flours for *Genfo* [porridge like food],

atmit a special drink (hot) made of barley flour and milk that helps mothers to produce breast milk after birth, *injera* [stable food made of grains mostly *teff*], and honey, cooking oil and butter, the mother would use while she is *Aras. Aras* is a new mother, and the time she will be taken care of at home by family members, friends, and neighbors. This time lasts at least for 40 days and moves up to 90 days depending on the sex of the new born baby, religious affiliation and/or socioeconomic status of the family. If the family is Christian, the time of *Aras* ends after the child's christening, which is 40 days for boys and 80 days for girls. If the family is Muslim, the baby's sex will not have an impact on the days of *Aras,* but the families' socioeconomic status will.

Figure 24 Genfo- served with yogurt

1. **Rituals During Pregnancy**

During the interview Mesert talked about her preparation while she was pregnant as "I prepared everything I need, including flour for genfo and atmit while I was pregnant. When my mother came to help me during birth, she cooked me genfo if I crave for it, and atmit, injera". "መጀመሪያ ሳልወልድ በፊት የምፈልገውን ያው ገንፎ የሙቅ እህል አደራጀለሁ እናቴ ስትመጣ ያው የምፈልገውን ገንፎ ካሰኘኝ ገንፎ አጥሚት አረጋ እንጀራም በጋጋሪ ያው እንደዛ ነው ::" After giving birth, Mesert was able to eat what she craves for and whenever she wants because she was *Aras,* she has prepared everything she needs while she was pregnant, and her mother was there to take care of her.

In addition to preparing various food ingredients, there is a traditional as well as spiritual ritual that would be performed during the last week of pregnancy. This ritual is called *genfo kemesa* [testing of genfo] and *Fatima Kori. Genfo kemesa* is a traditional ceremony held by Christians to test the flour for *genfo*. In this ceremony, *genfo* will be prepared at the expecting mother's house; family, friends, and women in the neighborhood will be invited. The guests will eat the *genfo* blessing the mother and praying for the healthy and peaceful delivery of the new baby. *Fatima Kori* is often linked to Muslims, but it is also carried out by Christians. This ritual is mixed with a traditional spiritual ritual called "*Erfo Mereba":* a musical prayer for healthy delivery of the new baby, led by "*Dubertis",* elderly women who are bestowed a special power (spirit). Explaining these traditions and rituals Alem said "about a month before birth, the neighborhood will be invited to genfo kemesa. And within the Muslim community they perform *Fatima Kori." "*መውለጃዋ ከመድረሱ 1 ወር አካባቢ ሊቀራት አካባቢ ይጠራል ገንፎው መቀመስ አለበት ስለሚባ ሙስሊሙ ጋር ፋጢማ ቆፈ ይደረጋል ክርስቲያኑ ጋር ደግሞ የተዘጋጀውን እህል ቅመሱት ይባላል ይላሉ ይመረቃል"

Emama Halima explained the rituals during *Fatima Kori* as:

> Families, relatives and all the neighborhood will be invited. Whoever attends the ceremony brings oil or flour or as much money as she can as a gift. Then the musical prayer "*mereba"* will be done, blessings will follow. Afterwards, the mother gives birth at home peacefully. But currently, even if mothers perform *Fatima Kori* they tend to run to the health facility. *Fatima Kori* is a prayer and prayer is good. Feeding and helping the destitute is also part of *Fatima Kori*.
> ዘመድ በሙሉ ይጠራል ዘይቱንም ዱቄቱንም ይይዛል የሚመጣው ሰው 100ም የያዘ 50ም የያዘ ይይዛል እንዳቅምሽ ነው እንግዲህ ሁነኛሽን ነው እንግዲህ የምትጠሪው ዝም ተብ አይጠራም። ያው የአካባቢሽ ሰው ጎረቤትሽ አይቀርም ሁሉም ይጠራል። በአሁኑ ጊዜ ግን ፋጢማ ቆሪ ቢደርግም ምጥ ጀመር ሲያደርጋት ያው ወደሃኪም ይዞ መሮጥ ነው። እንግዲህ ፋጢማ ቆሪ የሚባለው ያው እንግዲህ ዱአ ደግ ነው ተብሎ የተራበውን የተጠማውን አብልቶ አጠጥቶ ያው ቀኗ ሲደርስ ፈጣሪ ቆሪ ያደርጋል

Million also explained the ritual of *Fatima Kori* further saying: *"*It is carried out by both Christians and Muslims. When we are due, the lady [*Duberti]* will come to the expecting mother's place and perform prayers. They also chant "Erfo Mereba". The ritual is carried out during the first birth for healthy and easy birth." *"*ክርስቲያኑም እስላሙም ነው የሚያደርገው የሚደረው አርግዘን ሆዳችንን ሲሞላ ነው ሴትዮ ትመጣለች ይለማመንላታል እንደውም እርፍ መረባ ይባልላታል እኛ ወላዶች እንኳ እየተውን ነው ያልወለዱ ገና መውለድ ያልመከራቸው (የመጀመሪያ ልጅ) ያው በደህና እንድትወልድ ተብሎ ነው የሚደረገው ::"

Aynalem further clarified how Christians and Muslims share rituals that are integrated to the tradition of the community through time using the following example:

> We eat genfo. Muslims as well as Christians perform Fatima Kori in this area [Raya Kobo]**.** The coffee ceremonies on Wednesdays are called 'Abdoye's coffee'[4] by the Muslims as well as Christians, and if you go to Worke [a small village] both Muslims and Christians observe Kidane Mehret-'Virgin Mary's day'[5] and do not plough their land.
> ገንፎ ነው የሚበላው ሙስሊሙም ክርስቲያኑም ያረጋል እዚህ አካባቢ እሮብና የአብዶዬ ቡና ነው በየሚባል ክርስቲያኑም ሙስሊሙም ወርቄ ላይ በኪምሀረት አያርስም ስለዚህ ሙስሊምና ክርስቲያን ተሳስሯል

Ayda, who is 29, married at 17, and a mother of 4, mentioned that she performed *fatima Kori* during her first pregnancy. She continued "Genfo was prepared and all families and neighbors were invited. The guests sat stretching their legs in front of them and gave a blessing wishing an easy and healthy delivery while chanting "Erfo Mereba". A prayer also followed".

[4] *Abdoye coffee* is a ritual that was primarily observed by Muslims and eventually inherited by everyone in the community. This coffee ceremony is usually accompanied by prayers and blessings for good health, good weather conditions, and healthy timely reproduction of livestock (cattle) (Tolossa, 2009)

[5] The 16th of every month is observed as *kidane Mehret* by the Ethiopian Orthodox Church- 'Virgin Mary's day'

“ፈጢማ ቆሬ የመጀመሪያ ልጇን ስወልድ ነው የተደረገው ገንፎ ይገነፋና ጎረቤትና ዘመድ ይጠራል። እርፎ መረባ እየተባ እግራቸውን ዘርግተው ምጡ ገር ይሁን እየተባ፣ ሹልክ ሹልክ ይበል፣ ወፍ አይሰማሽ ይባላል ዱአ ይደረጋል።

Alem added that during *fatima Kori, genfo* will be prepared with *telba* [flax seed]. Explaining the reason for this practice she said “if the people eat genfo with the flax seed, the labor will be smooth and easy for mothers just like the mixed flex seed ground”. “ፋጢማ ቆሪ ላይ ገንፎ በተልባ ነው የሚበላው ተልባ የመዝለግለግ ባህሪ አለው ገንፎ በተልባ ከተበላ እናቲቱ ስትወልድ ልጁ ሳያስቸግር ሹልክ ብሎ እንደተልባው ይወጣል ነው የሚባለው። “

Tayech confirmed that Fatima Kori is still practiced even if women use the modern facility based services during pregnancy. “we still perform fatima kori before birth. We also get prenatal services from the health facilities. They [health extension workers] told us to do our checkups every month”. “አለ አሁንም ፈጢማ ቆሬ አድርገን እንወልዳለን። ክትባት እንከታተለላን። በየወሩ 3 ግዜ እንከተባን ከዛ በኋላ በየወሩ እየመጣችሁ ክትትል አርጉ ይላሉ። እስከወለድን ድረስ እንሄዳለን።”

Even if most of my participants mentioned *Fatima Kori as* an important ritual, Sindu, had a very different view of this practice. She thinks that it is an outdated practice with no use to the community. And she added, “this ritual is fading these days. “Mereba” has no use. People who led this ceremony are now part of the development community group so they know better now”. “አሁን ግን እሱም እየቀረ ነው መረባ ጥቅም የለውም አሁንም ድሮ መረባ ይሉ የነበሩ ሰዎች እኮ በልማት ቡድን ተደራጅተዋል። ስለዚህ አውቀዋል እነሱም።”

Pregnant women will also avoid chores that are considered dangerous for them as well as the baby. The major two chores that were mentioned by participants often were going to flour mills and working outside in the field. Carrying flour from the flourmill on their back is believed to induce abortion, due to the heat, heavy weight and far walking distance. Therefore, this chore will be carried out by their daughter, if they have any, their husband, or family and friends. Women also stop helping in the field if they are pregnant.

Emama Halima explained *"*mothers avoided going to flour mills to protect them from the heat … since we carry the grain as well as the flour on our back." *"*ድሮ እንግዲህ እናት ወፍጮ እንዳትሄድ ይደረጋል። ያው እንግዲህ እኛ ተሸክመን ነው የምናስፈጨው ሙቀት እነዳይጎዳት " Tsige also mentioned that Mothers avoid working out in the field since they might get sick and may have a preterm birth which could lead to death of the baby as well as the other.

"ምች ይመታቸዋል። ካቅም በላይ የሆነ ስራ የሚሰሩ ከሆኑ ሜዳ የሚሰሩ ከሆነ - ከቀን በፊት ምጣቸው መጥቶ ለሞት ይደረጋሉ። "

2. <u>Rituals During Birth</u>

During birth the traditional birth attendant who lives in the neighborhood will be called to come to the mothers house. She will examine the woman in labor by touching and looking, without any additional tool. Her intimate friends, sisters and mother can go into the labor room to provide emotional support and say prayers. They will all be chanting "Mariam, Mariam, Mariam". Men including the husbands are not allowed in the labor room, until the baby is delivered and the room is cleaned. If the labor is difficult the husband will be told to unfasten his belt. Explaining this ritual, Fenta said " in our village the husband will be told to unfasten his belt and everyone with chant "Mariam, Mariam" since Mariam is the spirit of child birth."

“ለምሳሌ እኛ አካባቢ ቀበቶህን ፍታ ይባላል ድጅ ይሆናል ቀበቶ ይፈታል ከዛ ደጅ ያለ ሠው ደግሞ ማርያም ማርያም ይላል እኔማ ማለት ነው ሌላ ቦታ እርሻ ይባላል ከዛም እናትየው ትወልዳለች።“

ALEM added

> During labor the traditional birth attendant and neighbors will be in the labor room. The traditional birth attendant will be at one side and the neighbors will be at the opposite side chanting “Mariam Mariam”. The husband will be outside by the door and unfasten his belt. If he has fastened his belt, it is believed that the labor will be hard. If he unfasten his belt, just like the flax seed analogy, the labor will be easy and smooth. በምጥ ወቅት የምታዋልድ ባልቴትና ያው ጎረቤት እቤት ይገባል ባልቴቱ በአንድ ወገን ትሆናለች ሴት ጎረቤት ደግሞ ጥል ላይ ተቀምጦ “ ማርያም ማርያም ማርያም” ይላል ባየው ደግሞ ደጅ ላይ ሆኖ ቀበቶ ፍታ ይባላል ቀበቶ ከታጠቀ ምጥ ይጠናባታል ይባላል። ቀበቶ ከፈታ ግን ልክ እንደተልባው ማት ነው ምጥ ይጠናባታል ይባላል ቀበቶ ከፈታ ግን ልክ እንደተልባው ማለት ነው ምጥ ዝው ብሎ ይወጣል ይባላል። ባል ብቻ ነው ቀበቶ የሚፈታው ሌላው አይፈታም።

If the baby is a boy, the women inside will buzz “elelele” seven times and if it is a girl the do it three times. After the baby is born, the placenta will be buried in the backyard. Burial of placenta has a very significant meaning as it shapes the sense of belongingness in a specific community. It is not unusual to hear people talk about the village of their birth as their place of origin relating it to ‘their placenta’ – **“እትብቴ የተቀበረበት”.** After the placenta is buried, neighbors and families take all the cloths to the nearby river [around dawn or dusk] to wash it.

Sinidu explained this tradition saying:

> We used to wash the clothes at *Hormat* river or we would wash it at home, before the spread of HIV/AIDS. So when we return back after washing the clothes we will eat *genfo* celebrating the new birth. But now, due to HIV/AIDS neighbors don’t wash clothes. We know that HIV is transmitted through blood contact”.

> እናት ስትወልድ የማርያም መሸኛ አለ- የደም ጨርቅ ሆርማት ወንዝ ሄደን እናጥብ ነበ። HIV / AIDs ከመስፋፋቱ በፊት - ወንዝም ካልሆነ በሳፋ እቤት ውስጥ እናጥብ ነበር። ወዲያው የማርያም ገንፎ ይገነፋል እሱን እልል እያልን እንበላለን እናቲቱ ትታጠባለች ልጅቱ ትታጠባለች ወንድ ከሆነ 7 ጊዜ ሴት ከሆነች 3 ግዜ እልል እንላለን። ከዛ በ3ኛ ቀን ወንዝ ይወረዳል። ወንድ ከሆነ መሳሪያ ይሰራለታል ሴት ከሆነች እንዝርትና ወንፊት ይሰራል ከዛ

እየተጨፈረ ይመጣል ገንፎ ይገነፋል እቤት በ7ኛ ቀንም ወንዝ ይወረዳል ሆርማት እየተጨፈረ ይመጣል (ልብስ ይታጠብና ማለት ነው) ገንፎ ይገነፋል፤ የሳት እራት ነካ ነካ ተደርጎ ዋናው ይታጠባል ከ3 በ3ኛ ቀን በ7ኛ ቀን በደንብ ይታጠባል በ3ኛ ቀን -በ7ና ቀን በደንብ ይታጠባል፡ ፤ አንባሳ ወልዷ እያልን ከሆርበት ወንዝ እየዘፈንን እንመጣለን። ወንዝ መውረድ ከቀረ በኋላ ደግሞ በ3 ቀን ነው የምናንከው ሁሉንም። አሁን ግን እድሜ ለ HIV ት/ት ምንም የለም ልብስ አይታጠብም የመንደር ሰው ፣ ጎረቤት ልብስ አያጥብም በደም ንኪኪ HIV እንደሚተላለፍ ካወቅን በኋላ።

If there is complication during pregnancy and/or birth, traditional birth attendants will try to correct it. If the baby is breeched, they [traditional birth attendents] carefully massage the mother or use household materials during birth, or held the mother upside down. Explaining this situation Hizbe said " my mother gave birth to all of us at home. The way she gave birth is different based on the type of labor. They do so many things; they use Quuna (a large bowl) and wobble the mothers" "እናቴ እቤት ነው የወለደችው አወላለዱ ደግሞ እንደምጡ አይነት ነው። ኧረ ብዙ አይነት አለ። በቁና ያዋልዷቸዋል ፣ እየወነወኑ ያረጓቸዋል።"

Ayda added

> Traditional birth attendants correct the position of the baby. In hospital if a baby is breeched they do c-section but at home they correct it by massaging it with butter. If the placenta is retained, they all rush the mother in to hospital; if there is a hospital nearby, but if not, they will put *berbere* (chilli poweder) in the charcoal flame hoping the placenta will be born when the mother sneeze. If there is a bleeding problem, guns will be fired and she will be given a leaf that would be used to stop the bleeding. She will hold on to the leaf for a while and the bleeding will stop.
> ያስተካከሉታል- ሆስፒታል ልጄ በእግሩ ቢመጣ ሆፕራሲዎን ነው የሚያደርጉት እነዚህ ግን ያስተካክሉታል። አሸተው በቂቤ ያስተካክሉታ እንግዴ ልጄ ግን እንቢ ቢሉ ሃኪም ቤት መሄድ ነው። ሃኪም በቅርብ ከሌለ ግን እንግዴ ልጅ እንቢ ቢላ በርበሬ ያጥኗቸውና ሲያስነጥሳት ይወጣል ይባላል ደም ሲባዛ ደግሞ ጥይጥ ይተኮል ቅጠል ቆርጠው ያሹላትና ያስጨነብጧታል። ከዛ ደሙ ይቆማል የደም ማቆሚያ ቅጠል አለ።

Fenta also added that a religious leader, who will recite prayers, will be called to stop the bleeding.

Birthing is considered a traumatic experience for the mother, whether she gave birth at home or at a health facility. Hence, they [mothers] require time and care to heal and get back her strength. Her mother [if she is alive] is culturally responsible to provide care and support to her *Aras* daughter during the first birth. Hence, research participants explained that woman often go to their parents' house to give birth, and their mothers are responsible for taking care of them during the 40 days after birth. If the expectant mother cannot go to her parents for various reasons, then her mother will come and stay with her for at least for 40 days, and take care of her. If she [the expecting mother] does not have a mother, close relatives or friends or neighbors take care of her during the 40 days. Tayech said "after I gave birth I was taken care of for 40 days. I stayed home and everything I need was prepared for me." "ከወለድኩ በኋላ ደግሞ 40 ቀን እታረሳለሁ ከቤት ሳልወጣ እቤት ውስጥ እቀመጣለሁ። ሁሉ ነገር ይዘጋጅልኛል " Million also confirmed the tradition after birth saying

> I never left my house until the christening [after 40days]. I am always accompained by my friends or my mother even to go to the toilet[6]. My inlaws also broght me *woira* and all the necessary woods for *bolekya.* My mother was the one who take care of me after I gave birth-—for both children. The first time I went to her place.
> አራስነት እንግዲህ ክርስትና አስካነሳሽ ወጥቼ አላውቅም ሽ/ቤትም ስሄድ ከሰው ጋር ነው ከቤተ ጢስ እየሞኩ ነበር የባሌም ወገኖች ጢስ የምሞቀው ወይራ ምናምን በደንብ አምጥተውልኛ። እናተ ነች ሁለቱንም ስወልድ ያረሰችኝ እኔ ጋር መጥተው ቤቷን ጥላ መጥታ ነው ያረሰችኝ ለሁለተኛው ልጄ የመጀመሪያውን ስወልድ እናቴ ጋር ሄጄ ነበር የታረስኩት

During the time of *aras,* families, friends, and neighbors visit and congratulate the mother. Zere said " congratulating the mother is the norm and the tradition in out community. We all go to visit and hangout with the her after she gave birth" "ደንብ ነው

[6] Toilets are placed outside the house, usually at the corner of a backyard

ወግ ነው፤ አንኳን ማርያም ማረችሽ ይባላል እኛም የወለዱ ሲሆን ነሄደን ቁጭ ብለን ተጫውተን ተመልሰን እንመጣለን”

Debre added that “Mothers stay at home for 40 days with someone. She can never be left alone during these days. To restore her strength and her health she will be fed quite often. To give birth is like to be born again.” “እንግዲህ እናት ወልዳ 40 ቀን እስኪሞላት ድረስ ጥለዋት አይወጡም ብቻዋን በፍጹም አትቀመጥም። አካላዊ ጤናዋን ለመጠበቅ ደግሞ ያው በወለድሽ ወቅት አንዲት ሴት ምግብ ቶሎ ቶሎ ካልወሰደች፣ ትጎዳለች ስለዚህ ቶሎ ቶሎ ምግብ ይሰጣቸዋል። መውለድ መልሶ መፈጠር ማለት ስለሆነ”

Aras also has social privilege. Hirut said “Aras is very respected! If you go to visit Aras, you will also be treated well. Neighbors provide care for her even if she doesn’t have her mother or her family around”. “አራስማ በጣም ክቡር ነው። አራስ ቤት ብትሄጅ ለአንቺም የሚደረገው ሽርጉድ ደስ ይላል። ጎረቤ በጣም ነው የሚንከባከባት ፣ ቤተሰብ እናት የሌላት ከሆነ እንኳ ጎረቤት በደንብ ነው የሚንከባከባት።” Misre added “neighbors will wash the diapers and prepare food and feed the aras if her mother or her sister is not around” “እናት ካለቻት እናቷ ቤት ትቀመጣለች ከሌለቻት እህት ጎረቤቱም ሽንት በማጠብ ውሃ በመቅዳት ምግብ እራሱ ሰርቶ በማብላት ይንከባከባታል።” Tsige also mentioned that neighbors, friends, families will bring whatever they can: home baked bread or injera, to visit the Aras. Aynalem added “I have a friend who recently gave birth. There are nine of us who drink coffee together, so we take turns to care for her since she doesn’t have family nearby.” “አሁን ጓደኛችን ወልዳለች እቤት ማንም የላትም ዘመድም እሩቅ ነው ስለዚህ 9ነን አብረን ቡና እምንጠጣው በየተራ እየሄድን ነው የምናያት”

In many parts of North Wollo, *Aras* use *Bolekeya. Bolekeya* is a traditional smoke based spa that uses different aromatic plants such as *woira* [african olive], *woiba* and *agam*. In North Wollo, houses have a small designated space with a hole for making a smoke that would be used for *Bolekeya*. Hence, the new mother sits in the infumed room, while eating well prepared grains (such as millet, sorgum and wheat) and drinking milk and/ or soup to keep hydrating herself. Research participants mentioned the medical as well as cosmetic values of *Bolekya* for mothers as minimizing the postpartum bleeding and serving as a great fragrance to mothers as well as the house.

Alem discussed the social significance of *bolyekya* saying

> In our community you gauge the love and respect of your husband by his effort to get the right plants with the right quality for *bolekya*. He would start looking for roots and branches of specific trees when his wife is about 3 months pregnant. Then he will cut it to the right size and store it. This happens before preparing the flour for *genfo* and all the other ingredients such as butter and honey.
> በኛ አካባቢ በገጠሩ ሚስቱ እርፍዝናዋን አውቆ በተለይ 3 ወር አካባ ከሆናት በኋላ መጀመሪያ ሰባለቅያ የሚያስፈልጉ ስራስሮች አሉ ላንቺ ትልቅ አክብሮትና ፍቅር ያለው ባ ከሆነ በተለይ ወርቄ/ ዞብል አካባቢ ስትሄጂ ስራ ስሩን እየፈለገ በአጭር በአጭሩ ለክቶ አየቆረጠ ያዘጋጃል:: ከዛ በሁላ ነው የገንፎ እህሉ ሙቁ ቅቤው ማሩ የሚዘጋጀው

The value of care and support *Aras* gets during the 40 days after birth vary based on her socioeconomic status. Even if the basic food consumed during this time i.e. *genfo,* and *atmit* is similar, mothers from relatively better family would eat more meat, butter and honey. Emama Halima highlighted the difference between the haves as and have not in the following manner:

> We make *genfo* for *aras.* There is also a small hole in the house for Bolekeya. If she is rich her husband and family will slaughter a sheep for her. Neighbors will come visit her bringing various types of food. If she is sociable and visited mothers in the community, she will have a lot of visitors. Neighbors pay back their debts. If you are from a well to do family, you tend to have more visitors and people bring more than you need. But if you don't have, then there is nothing!
> ገንፎ ገነፋላታል:: ጉርጓድ አለች እቤት ውስጥ የተመረገች እንግዲህ ጢሷን እየሞቀች ትቀመጣለች ሃብታም ከሆነች ደግሞ ይታረድላታል። የአካባቢው ሰው ይመጣል

ይጠይቃታል ስቅስቅ ወጥ ቅቤውን ክክም ዶሮም ገንዘብ ያለው በግም ሽንጥም ይዞ መጥቶ ይጠይቃል ያው እንደ አኪኋንሽ ነው ውለታ ያለው ሰው ከሆነ የአካባቢው ሰው ይመጣል ውለታውን ይመልሳል። ያው እንደሁኔታሽ ነው ከፍታም ከተወለድሽ ይኖርሻል ያው ድሃ ከሆንሽ ደግሞ የላሽም ከየት ይመጣል ያለው ዘመድ ካለሽ አንዷ አክስት በግ አንዱ ዶሮ ይዞ ይመጣል ለመብላትም ይቸግርሻል ከሌለ ግን የለም።

Mulu added

mothers prepare what they can afford. But, she will stay home at least for a month. Her mother, her children and neighbors take good care of her. Neighbors will bring milk, soup, gravy, flour, home baked bread…anything they can afford. The community supports each other".

ያለውም ያርዳል የለለወም ያውእንዳለው ነው:: ያው እንደኑሮዋ ትታርሳለች መቼም ቢያንስ 1 ወር አትወጣም ምንም ቢሆን:: ልጅ ከሌላት እናት ከሌላት ጎረቤት በዚህ ወቅትይንከባከባታል:: ወተትም; ቅቅልም ; ዱቄትም; ዳቦም; ያለውን ይዞ ያካባቢው ሰው እየመጣ ያያታል:: ያካባቢው ሰው ይረዳዳል:: ዘመድም ባይኖራት ተራ ገብተው በደንብ አርገው ጎረቤቶች ያርሷታል::

However, Hizbe challenged this comment saying "Yes we say Aras stays home for 40 days but if she has no support and if her husband needs to go to the farm, she will start cooking after 15days. She will not go out to collect firewood or fetch water, but she carries out household chores". "40 ቀን ይባላሉ ግን ቤት አጋር ከሌላት፣ ገበሬ የምትሸኝ ከሆነች ከ15 ቀን በኋላ እየወታች ማብሰል ትጀምራለች። እንጂ ትጋግራለች ወጥ ትሰራለች ያው ውጭ ላይ እንጨት ውሃ ባትልም የቤት ስራዎችን ታከናውናለች። "

The time of *Aras* is completed after christening of children for Christians. The mother will be baptized with her child and restart her normal routine. For Muslims it is after 40 to 90 days depending on the socioeconomic status of the family.

Identifying and comprehending traditions and rituals is very important to understand maternal health needs, and pre and postnatal service seeking behavior of mothers which will be discussed in the next chapter.

V. FINDINGS CHAPTER II: MATERNAL HEALTH NEEDS, AVAILABLE SERVICES AND THE GAPS IN SERVICE DELIVERY

A. What Do Mothers' Need? Research Participants Reflection and Response

Participants identified access to nutritious food, clean water supplies, health facilities, housing, education, and economic empowerment as major needs of mothers in the community. Research participants also indicated that mothers need to satisfy their basic needs to stay healthy and active. Ayda said "a mother needs nutritious food, shelter, and someone who can help her with household work" *"*ጥሩ ምግብ ፣ ስራ ባይበዛባት፣ የቤት ውሥጥ ስራ ከጎን የሚያግዛት ትፈልጋለች" and Selam also explained it further saying *"A mother needs to eat, be clothed, and kept clean."* "በደንብ የምትበላው የምትለብሰው ነገር መዘጋጀት አለበት ጡሃራ መሆን አለባት፣ የምትበላው መለየት አለበት፣ እናት መከብከብ አለበት". Zebenay added "a mother has to keep her personal hygiene and she has to eat nutritious food on time otherwise she will be hurt. She also has to rest. She needs to be protected from work burden." "ልብሷን ማጠብ፣ ንፅህናዋን መጠበቅ የምግብ ጉዳት እንዳይደርስባት በወቅቱ መመገብ፣ ተለያዩ ምግቦችን መብላት፣ የስራ ጉዳት ደግሞ በጣም እንዳይደርስባት መጠንቀቅ በወቅቱ ሰርታ በወቅቱ ማረፍ አለባት"

Desta also confirmed that access to healthy food and sanitation is the key for maternal health. She continued "if a mother doesn't get what she needs during pregnancy, she won't have enough energy to push during labor. Since C-section is considered a bad practice, it won't be an option. Thus, during delivery, she might be exposed to various risks including death" *"*አንድ እናት የነፍሰጡርነቷ ወቅት የምትፈልገውን ካላገኘች በምጥ ወቅት የማመም አቅሙ ይቀንሳል በዚህ አጋጣሚ ደግሞ ቢያንስ ኦፕሬሽን ብትያቸው እዚ ሃገር የሚያውቅ የለም ኧረ መጥፎ ነው ኦፕሬሽን ምናምን ስለሚሉ

ለማማጥ አስቸጋሪ በሚሆንበት ግዜ ለሞት አደጋ የሚጋለጡ እናቶች ብዙ ናቸው” Emama Halima also confirmed that if mothers have access to healthy food she can easily heal even if she gets sick.

Hizbe added regular medical checkups and access to health facilities to the needs of mothers. She said “especially in our village going to health facilities is important as malaria is prevalent. We need to drain all the stagnant water bodies and go to the health facility as soon as possible”. “ብዙ ግዜ ቶሎ ህማም ሲሰማት ወደ አካባቢው ጤና ኬላ ሄዳ መመርመር አለባ። ከዛ የታዘዘላን መድሃኒት / መርፌ በወቅቱ መውሰድ፤ እና ደግሞ እኛ አካባቢ ወባ አለ እነሱን ለማስወገድ ጤና ጣብያ በመሄድ ኩሬዎችን ማስወገድ / መሸሻ ሎላም ህመም የሚያመጣ ነገር መሸሽ ህመምም ከተከሰተ ደግሞ በፍጥነት ሃኪም ሄዶ ምርመራውን መውሰድ አለባት። “

In places like North Wollo, where drought and famine is a recurring situtation, and most community members depend on subsistance farming, access to food is a major challenge. Getting nutritious food is even more challenging. Articulating this challenge Bethel said “to be healthy mothers need to eat nutritious food, and get health services. However, the primary issue is their economy. If they can afford it, they can keep themselves healthy, but if not, they need support from the society” “ጤናማ ለመሆን ተመጣጣኝ ምግብ፤ የጤና አገልግሎት በጣም ያስፈልጋሉ። የመጀመሪያው ኢኮኖሚ ነው የተሻለ አቅም ካላት ጤናዋን መጠበቅ ትችላለች ድጋፍ ያስፈልጋታል እናት የማህበረሰብ ድጋፍ ያስፈልጋታል” Shewa also added “if a mother has no money what can she do? She will stay home, rest a bit, tie her head, and cry. There is nothing she can do. Poverty is real in our village” “እናት ያው እቤት እየተኛች እራሷንም እያሰረች ምንም እያለቸ ትሞታለች እንጂ ገንዘብ ከሌላት ምኑን ታሟላዋለች ያው ለቅሶ በቀር የማጣት ችግር በአገራችን ስላለ”

In addition, Serke said “health is parallel to one’s socioeconomic status. It is very difficult to stay healthy in this community due to economic deprivation. People die so young

because they are poor.” “ጤንነት እንግዲህ የንሮ ጉዳይ ነው እንግዲህ የሃገራችን ድህነቱም ስላለ ጤንነትን ጠብቆ መኖር የሚቻል አይመስለኝም ያለ አግባብ መቼም ሰውን ከጤናው የሚያጎድለው የንሮ ሁኔታ ነው።”

Sinedu, who was a traditional birth attendant and now community educator, elaborated how socioeconomic conditions influence maternal health saying:

> We teach the community. But when we do home visits there are people who are destitute. They spaced their children as we taught them, but they are poor. The community support each other. It is part of the tradition but the community cannot do much neither. Neighbors may share what they have today, but they may not have enough to share for tomorrow. So we cannot make a significant change by talking and teaching only. We need to help them change their economic situation.

> ቤት ለቤት ስናስተምር ፩ ለ ፭ ስንማማርም የምናገኛቸው ምንም የሌላቸው ድሃዎች አሉ። አራርቀውም ቢወልዱ ሁሉም ቤት ውስጥ አይሟላላትም እኮ ስለዚህ ትንሽ ድጋፍ ቢደረግላቸው ጥሩ ነው። ኢኮኖሚያዊ ድጋፍ ማለት ነው። ማህበራዊ ድጋፍ ያው ጎረቤቱም የአካባቢውም ሰው ያደርጋል። እንደራያ ከሆነ አይጠናም ይረዳዳል እኛ በአፍ ብቻ ለፍልፈን ብንወጣ ምን ጥቅም አለው? ከሌለ የለም ገንቢ ምግብ ለተገኝ ትችለች እኔ ዛሬ በሰቱት ነገር ላልሰጣት እችላለሁ። ስዚህ ኑሮው የሚሻሻልበት ነገር ቢኖር

Research participants also mentioned that mothers need to get access to finances through formal and/ or informal employment to take care of themselves. Misre said “mothers need money to be healthy and she needs to be healthy to make money. If she is healthy she can sell her labor and make money [if she lives around towns]. She may fetch water and/ or help with chores in the community”. “ገንዘብ ያስፈልጋታል 2ኛ ጤንነቷ ያስፈልጋል ጤና ከሆነች እቤቷ እንካ ባይኖራት ሰርታ የምታገኝበት መንገድ አለ ለምሳሌ የሌላት እናት ከሆነች ውሃ ቀድታ በጀሪካን 5 ብር ነው ቀድታ ታድራለች ስለዚህ የሚያስፈልጋት ትልቁ ነገር ጤና ነው።”

Million, who sells homemade alcoholic drinks from her house, added

> Mother needs money to protect herself and be healthy. She needs a house and some clothes. House is a priority. Many leave their neighborhood when their rent

increases, because they can't afford it. But if she has her own house, she can use it to run some business and make a living.

ጤናማ እንድትሆን በቂ ገንዘብ ያስፈልጋታል ገንዘብ ስታጣ ነው ሌላ ቦታ ገብታ እንትን የምትለው ራሷን ጠብቃ ሂወቷን ጠብቃ መኖር አለበት መጠለያ ቤት ያስፈልጋታል፣ ልብስ ያስፈልጋታል ቤት ግን ዋና ነገር ነው በማጣት የተነሳ አሁን ብዙ ሰው የማይፈልገው ቦታ ይዳል ኪራይ ስለሚጨምር ማለት ነው ቤት ካላት ግን ቤቷ የሆነ ነገር እየሰራች መኖር ትችላለች።

The other important point that was raised by most participants as mother's need is less housework burden. Mente said "mothers should minimize their household chores during pregnancy. Her husband has to help her to avoid stress and depression" "እንግዲህ እናት ካረገዘች ጀምሮ እስክትወልድ ድረስ የስራ ጫና መብዛት የለባትም፤ የምግብ ስነስርዓት መውሰድ አለባት እሱምስራ መርዳት አለበት ጭንቅላቷ እንዳትመርዝ እንዳታስብ መርዳት አለበት"

Mulu and Hizbe also said that mothers need to rest, space her pregnancy and eat well. Birhan also added a back pain could result from having many children, thus mothers need to space their pregnancy and control their birth.

Kinde, who is a health extension worker, added that mothers need to get prenatal and postnatal care from the health facilities available in their community. Sinedu added "pregnant women need to be stress free and she needs affection. If her mind is free, then she is free; she won't be sick." "የተሟላ የወሊድ ክትትል ያስፈልጋታል፣ የተሟላ ምግብ ያስፈልጋታል ንጽህና ያስፈልጋታል ንፁህ መኝታ ያስፈልጋታል እናት ሰው ፍቅር ደግሞ ለነፍሰ-ጡር እናት ቀርቶ ለማንም ሰው ያስፈልገዋል። አይምሮሽ ነጻ ከሆነ ነጻ ነው የምትሆኚው በሽታ አታገኚም። "

In contrast to research participants that did not go through formal education system or who cannot read or write, participants who had completed high school, who are involved in community based activities as well as health extension workers, identified education as mothers'

need. They stressed that mothers need to know more about pregnancy, birthing, nutrition, child care and women's rights. Selam indicated that mothers need to discuss their issues, be educated and use the health facility in their community.

Zebenay showed how education eventually changed situations for women in her community saying:

> In the past nobody cared if a woman is sick or tired. It is not like today. Women were not equal to men. But now through awareness raising education both men and women know better and men have started to consider women as important.
>
> በፊትማ ቤት ቢያማት ቢደክማት ብትወልድም ምን አገባሽ ይሄን ስሪ ነው እንጂ እነደዛሬው የሴቶችን እኩልነት በማየት የለም ነበር። ዛሬ ግን ሴቶችን እንደራስ አድርጎ በተማረው ት/ት ወንዱም ሴቱም እኩል ስለሚማር ሴቷም ለካ የኔ ገንዘብ ናት ብሎ በልብ አድርጎ ይንከባከባታል።

Desta added "Mothers need education. If we see health related issues, many women did not have access to public education. Mothers who cannot read and write can't do much so we need more education that is tailored for them". "ለእናቶች ት/ት ያስፈልጋቸዋል በጤና ዙሪያ አሁን ብዙ እናቶች መጥተው አልተማሩም ያው የተወሰኑት የሚያውቀው ሰው ካሆነ መጻፍ ማንበብ የሚችለው ካልሆነ የማይችሉ እናቶች ስብሰባ አንድ ነገር ማድረግ አይችሉም እና የበለጠ ት/ት ቢሰጣቸው ለጤናቸው ያሻሽላሉ የሚል ግምት አለኝ "

B. <u>Available Maternal Health Services</u>

Research participants discussed different services that are available within their community and/or village generally. Examining their responses, I have categorized these maternal health services into traditional community based services and policy led facility-based services.

1. **<u>Traditional Community Based Maternal Care [Prenatal, Natal and Postnatal Care]</u>**

Participants portrayed their community as collectivist: a community where families, kin and neighbors support and accompany each another during happy and tragic moments. Emama Fate said "we lived together sharing a kitchen and cookware. It is the same now for people who like each other. There is no problem." "በአንድ ምጣድ ጋግረን በአንድ ብረድስት አብስለን ተሳስበን ነበር የምንኖረው አሁንም ያው ለተዋደደ ያው ነው ምንችግር አለው ምንግዜም እኮ ፍቅር ነው":: Hizbe added "in rural areas there is a culture of collaboration. People visit their relatives and families and they have strong relationships with uncles and aunts, cousins and kin" "የገጠሩ ደግሞ ከሰው ጋር አብሮ መኖሩ መተዳደሩ አለ። ዘመድ መጠየቁ ፍቅሩ ጥሩ ነው። ከዘመድ አዝማድ ጋር ከአጎ ከአክስት ጋር ከልጆች ጋር በደንብ እንቀራረባን ከውጪ ሰው ጋር ቢጠሩ የመተባበር ባህሪ አለ"

Alem also mentioned

> There is an established kinship care system in the community that compels families, relatives and kin to support each other. Even if these ties are loosening due to the economic hardships, they are important to uphold the sense of responsibility and accountability built in the relationships.
>
> ግን ማህበረሰቡ በባህሉ የቤተሰብ ዝምድና ግሩፕ አለ አክስት/እህት ከሆኑ ያው ሰው ምን ይለኛል ብሎ ይፈል። የተወሰነ ግዜ ያው በረከቱ እንዱደርሰኝ ልረዳ ብሎ ይረዳል። አሁን ግን ያ እራሱ እያሳሳ ነው ካለው ኑሮ ሁኔታ የተነሳ የቤተሰብ ትስስሩ እየላላ ነው። ከመጥፋቱ በፊት መንግስት አንድ ነገር ቢያደርግ ጥሩ ነው።

Therefore, mothers have structured community/neighborhood support starting from pregnancy to birth and during the 40 days after birth. Tsige said that community support is fundamental for mothers. "Her husband and children take good care of the mother. The community is great as well. She will be accompanied by her neighbors during the good and bad times, including delivery. She won't be left alone" "ባል በደንብ ሚስቱን ይንከባከባል፣ ልጆችም

ካሏት የሃገሬው ሁኔታ ጥሩ ነው። አሁን ልትወልድ በምትሄድበት ግዜ ያው ከሰው ጋር ሆና ነው ከጎረቤት ጋር ነው ብቻዋን የምታደርገው ነገር የለም ውጣ ውረዱም ከሰው ጋር የተያያዘ ነው። ርህራሄው የሁሉም ነው።" Desta added: "when I gave birth neighbors bring food and drinks. I will also do the same if my neighbor gives birth. It is the same if someone gets sick. We take care of one another" "ዳቦ፣ እንጀራ፣ የተለያየ ነገር የሚበላ የሚጠጣም ነገር ይዘው ይመጣሉ በወለድን ግዜ፤ እኔም ሰው ሲወልድ እንደዛ አረጋለሁ። ሲታመሙም ቢሆን እንደዚያው ነው። ሲታመሙ ለአራስም ሆነ ለሌሎች እንደዚያ እናደርጋለን"

Zere explained existing community support during birth as an obligation for friends, families and neighbors. She said

> we should go visit a new mother taking gifts we can afford. When I gave birth, I got support from my family and my neighbors. There was no health center or health office then. That facility was established only last year. If your labor is hard you need to go to Woldiya Hospital [60kms away] to deliver. I delivered my son in Woldiya.
>
> እናት በወለደች ጊዜ ሄደን መጠየቅ ካገኘንም ፍትፍትም፣ ሆነ ብርም ሆነ ይዘን እንጠይቃለን ያቅሙን ያህል ጓፈኛሽ ባልንጀራሽ ዘመድሽ ከወለደች ግዴታሽ ነው እኔ በወለድኩበት ወቅት ሀኪምቤት እንኳን ሄደን አንገላገልም ነበር እያልኩሽ ነው እነደገና ወልዲያ ነው። እኔ እንኳን ወንዱን ልጄን ስወልድ ወልዲያ ነው ጤና ጣቢያው የመጣው ገና 1 ዓመቱ ነው።

Birthan and Bethel added that caring for new mother has spiritual value. Birhan said "If you know a mother who gave birth you prepare something to eat or drink, whatever you can afford, and visit her. It is a kind act in God's eyes. You take care of the baby as well—give the baby a bath. However, these days it is hard due to the HIV epidemic." "ጎረቤት/ ማበረሰብ እንግዲህ በአቅምሽ ያው እከሌ ወለደች ሲባል ያለውን ነገር ሰርተሽ/ ገዝተሽም ሆነ አራስ ትጠይቂያለሽ ይህ በእግዚአብሔር ዘንድም ጥሩ ነው። ህፃኑን ትከባከቢያለሽ፣ ታጠቢያታለሽ፣ በጣም ቀርበሽ ለመስራት ለማጠብ ግን አሁን ግዜያችን ጥሩ አይደለም ከኤች አይቪ ጋር የሚኖር ሰው የበዛበት ዘመን ነው::"

Bethel expalined

> neighbors take care of *Aras* [new mothers] and help manage their household, especially if she doesn't have a mother or a family around. Someone [from the neighbors] will fetch water, the other wash diapers, and the other prepare food. So neighbors share that burdon and cooperate. Fetching water for *aras* is considered a gate-way to heaven.
> የአካባቢው ሰው አራስን በደንብ ነው የሚንከባከበው። እናት ከሌላት ቤተሰብ ከሌላት በተለይ የሰፈር ሰው በየተራ እናትን የሚያግዙት አንዷ ውሃ ትቀዳለች፣ እንዷ ሽንት ጨርቅ ታጥባለች፣ አንዷ ምግብ ታዘጋጃለች። ስለዚህ በጣም ነው የአካባቢ ሰው ጎረቤት የሚተባበረው እንዲያውም የማርያምን ውሃ የቀዳ ተብሎ አራስ የጠየቀ እግዚአብሔር ደጅ ያስገባል ስለሚባል በደንብ ነው የሚተባበረው።

The often mentioned traditional community based care and support for mothers comes from their children, husbands, families—mothers, sisters, aunts. Examining the responses most of the articulated help is from other women. If research participants discuss about men, it is usually the husband providing/buying the necessary ingredients to prepare the right food such as honey, butter, and variety of grains; and helping in major household activities such as fetching water, preparing firewood and going to flourmill if there is no other support.

Million said "children take care of their mothers. She gave birth and nurtured us, thus we have to payback our debts. We [children] take her to the doctor, encourage her and wash her clothes when she gets weaker and older"

> መቼም ቆማ እየተንቀሳቀሰች ምንም አይመስለንም ሲያማት ስታረችጅም አይዞሽ እያለን እየደጋገፍን ያማትም ወደ ሃኪም ቤት እየወድን ልብሶቿን እያጣጠብን ማንከባከብ ነው እና ወልዳ አሳድጋኛለች ስለዚህ ግዴታ አለብኝ ብድሯን መክፈል አለብን። ያው እናትን የሚንከባከባት ልጅ ነው ባቤቷ አዎን የአካባው ሰው ግን ሌላ ፀባይ ካለሽ ገለጽ ገለጽ ያደርጉሻል

Emama Tenagne also felt more safe and supported because she has older children she can rely on. Debre mentioned that husbands care for their wife: mothers by providing what she eats after she gave birth. Mente added that her mother take care of her by cooking what she eats and managing the household while she is *Aras.*

Traditional birth attendants (TBAs) are also portrayed as the main support providers for expecting mothers in rural communities, whether the mother decides to have home or facility based delivery. For mothers who deliver at home, traditional birth attendants assist them throughout the process: delivering the baby, cutting the chord, cleaning and wrapping the baby, for free. And for mothers who decided to go to the health facility during birth, they will accompany them to the health facility since it's difficult to predict delivery time and anything can happen on the road. Traditional birth attendants (TBAs) prepare the yarn they would use to tie the umbilical cord, a new blade to cut the cord, clean cloth to wrap the baby, and all the remedy to deliver retained placenta [in case that happens]. They are always prepared for the unexpected.

Fenta said "a mother will ask the traditional birth attendant to accompany her to the health facility. Then the TBA will accompany the mother having all the tools and remedies ready, including the ones she would use for pulling retained placenta [if occurred]" "ወደ ሃኪም ቤት በምትሔድበት ወቅት አሞኛል ተከተይኝ ትላታለች ከዛም አዋላጇ መዳኒቷን የእንግዴ ልጅ ማስውጫ ይዛ ትከተላታለች ከዛም ሀኪም ቤት ከመድረሷ በፊት መውለድ ካለባት ምጥ ከመጣባት ታዋልዳለች ሀኪም ቤት ካደረሳት ግን አታዋልዳትም። "

Kinde highlighted "Woman can give birth on the road assisted by TBAs who accompany them to the health facility because they travel a long distance to reach the health facility". "እናት መንገድ ላይ ሊወልዱ ይችላሉ ከወለዱ ጤና ጣብያም የሚያመጡም አሉ የማያመጡም አሉ የማዋለድ የሚችል ሰው ያው ተከትሎ ነው የሚመጣው ምጥ የተያዘችውን እናት ማለት ነው።"

Aynalem also added:
Labor is like a flood. It is hard to predict the exact time of when it's happening. Even if you have your days right it could be 5 days before or after. You may even

forget your last day of menstruation. So you can do nothing if you are in labor except asking for help from traditional birth attendants. If I found a woman on labor, I will help her using plastic bag because gloves are not readily available. The priority should be keeping the mother and the child alive.

አንድ ጊዜ ምጥ ጎርፍ ነው ይባላል ምጥ ሚመጣበት ቀን ሲታወውም ላይወቅም ይችላል ቀኑን ቆጠርኩ እንኪን ብትይ 5 ቀን ሊቀድም ወይም ሊዘገይ ይችላል። የወር አበባ ያየሽበትን ቀንም ልትረሺው ትችያለሽ ስለዚህ ምጥ በምትያበት ግዜ ምን ይደረጋል የግድ የልምድ አዋልጅ አካባቢ ላይ ማገዝ አለበት እኔ አሁን ምጥ ተይዛ አንዲት ሴት ባገኛት በስነስርዓት አዋልዳታለሁ ፌስቱላም ቢሆን አስሬ አዋልዳታሉ መጀመሪያ መታየት ያለበት እናቲቱንና ህፃኑን ማቆየት ነው

Describing her 36 years of service to mothers in her community as a traditional birth attendant, Emama Tenagne said

I have delivered countless babies… I helped deliver four twins, and 3 breeched babies. But thank God the mothers and the babies were ok… There was a day I helped four mothers in one day. … I even helped mothers deliver in hospitals. The doctor told the mother that she had more time and left. I was in the hospital accompanying my other neighbor. That girl [who was told its not time yet] begged me not to leave her there. So I stayed with her and she was in full labor- I helped her deliver in the waiting room! The baby was born before the doctor returned back from the delivery room. … And I never charged those mothers a nickel. Those who can afford it will bring me some gifts to show their gratitude".

እ እንዲው እዚህ ያሉትን ቆጥረሽ ብትዘልቂ ብዙ ናቸው ከዛ ሁሉ 4 ሞንታ የወለዱብኝ አሉ፡ ፡ 3 በትክክሉ መጣ ብለን በቂጣቸቸው የመጡ ልጆች ነበሩ ሳለስተካክል እንዳለ ወለደችው የዛ ግዜ ግን ፍርሃን አደረብኝ አንዷ ጎረቤቴ ነበረች ባለቤቴን ቀሰቀስኩት ሃኪም ትሂድ እንጂ አለ ግን ግማሽ ከወጣ አይሰበስብ ምን ይደረጋል።

ወየው 4ም ይወለዳል፤ አንደኛ ሜት ሄጂ አንዷ ቤት እየተቀሰቀስኩኝ ሁለቱን አገልግዬ ደግሞ ወደሌላ ደሞ ወደሌ እቤቴ ሳልገባ 4 ያገላገልኩበት ቀን አለ።

አሁን እናቶችን ህፃናት ነፃ ህክምና መሆኑ ነው ሰው ሃኪም የሚሄደው ይከፍላል ከተባለ ግን አንዲት ደሀ ክፍል የት ትሄዳለች። እኔ ባገለግላት 5ሳንቲም ስጪኝ አልላትም በነጻ ነው። አሁን ደስ ሲላቸው ሰሙናም ገዝተው እትዬ ወርቄ ደስ ብሎናል ብለው ቡናም ገዝተው ነበር የሚያመጡልን እንጂ ይሄንን ክፈሉ ብዬ አላውቅም።

ሆስፒታል ውስጥ ሃኪሞችንም ረድቼ አዋልጄ አውቃለሁ። ሀኪሙ አሁን አይደለም የምትወልደው አለ እንዴ ለምን ተብሎ አልኩ ልጅቷ እማማዋ ጥለውኝ እንዳትሄዱ ብላ ኡኡ አለች። እንዷ በዛ ኡኡ ስትል እንዷ በዚ እነቴ ስትል ይችኛይቱን አዋለድኩና ያችያቱን ሄዶ እስከሚያመጣ ድረስ ልጅቷን አዋልድኩ ደግሜ ሁለት በአንዴ እንዲወልዱ ይዤ ሄጄ ማለት ነው።

Emama Tenagne also confirmed that women do give birth on the road while they are being taken to the health facility remembering how she ended up helping a woman who finally gave birth at the front gate of the hospital. She said “I tried to get her inside the hospital but it was impossible. Thus, I found a large carton outside so I lay her on the carton and screamed for help. And she delivered there.”

> አንዷ ደግሞ ልጅቷ ሰው ቤት ስትሰራ ኖራ ወደ ደ/ገሊላ እየሄድኩ ነው። ይቺን ልጅ የሚያሳድሯት- “ውጪ ምጥ ከመጣ ሆስፒታል ሂጂ እንጂ አንቺን አናረስም” ይሏታል። እየተንከባካት ሆስፒታል ትሄዳለች ከዛ ሆስፒታሉ ዳር ጋር አገኛትና “ምን ሆንሽ” ብላት ታሪኳን ታጨውተኛለች እና “ምጥ መቶኝ ነው ትለኛለች” ጨርቋን ጠለፍኩና አይዞሽ እያልኩ ሳንኪትት አልሆን አለ። ሆስፒታል ካርድ የሚወጣበት እታች ደጅ ላይ ስንደርስ ልጅ መጣ። ረጅም ካርቶን አገኘሁ እዛች ካርቶን ላይ አሰተኛሁና ድረሱልኝ አልኩ እዛው ወለደችው።

Emama Tenagne also mentioned that she helped another mother a couple months ago, who delivered on the side road.

> When I my neighbor was going to church she heard a noise and when she gets closer she found out that a woman is in labor so my friend called me. I went there and helped the woman who delivered on the side road. I used plastic bags instead of gloves because gloves are difficult to get. Then we took the mother and the baby to the hospital. But, I found out that the hospital gave away the baby girl to an orphanage, because the mother is destitute and has a mental illness.
> እንዴ በደንብ ነው እንጂ መንገድ ወለደች እንደውም አሁን ቅርብ ቀን በሽተኛ ናጽ ልጅቷ ወደ ገብርኤል ቤ/ክ ሲሄዱ ሴትዬዋ እል ስትል ይሰማ መንገድ ዳር ማለት ነው ቢቲኖ አርጋ ነበር የምትቀመጠው እናቲቱ ከዛ ድረሽልኝ አሉን ሄድኩ ፌስታል አስሬ አዋልጄ እትብት ቆረጥኩና ልጂን አሳቅፌ ሆስፒታል ላክሁ ከዛ ልጅቱንፈ ህጻናት ማሳደጊያ አሳደጓት

In addition to neighbors and kinship structures, there are existing community based associations that bring residents together fostering social ties and financial support. Some associations may center on neighborhoods collaboration considering the physical spaces, such as *kere* and *equb;* and/or religious affiliations such as *mahiber* and *senbete*. However, members can belong to more than one association simultaneously.

Kere or *idir* is the largest social and financial institution where members make monthly contributions that can be used during funerals. If a member or a close family of a member died, *Kere* arranges the burial, cover related costs and accompany families for at least three days after the funeral. *Kere* also lends necessary cooking and dining materials, chairs and tables, tents, and other utensils for members during significant events such as: christenings, graduations and weddings. *Kere* also lends money to members during medical emergencies. Women also have a subsection—*yeset idir*—where where they strengthen their social ties, and help each other in any event [good or bad]. Thus, research participants explain it as a socializing and information sharing platform.

Emama Fate strongly believes that *idir [Kere]* fosters community spirit since it brings the community together during difficult times and members create personal ties within the bigger structure hence they help each other during death, birth, or happiness.

Sinidu said *"Idir [Kere]* meetings are venues where a lot of people gather together. Hence it is a great place to raise awareness on any social phenomenon. Mothers also get information in these venues. If there is someone who needs help, members support each other". "እድር ብዙሰው የሚገኝበት ቦታ ነው ስለዚህ በስብሰባ ወቅት ያስተምራሉ። ይሄ ጥሩ ግንዛቤ ማስጨበጫ መድረክ ነው። እናቶችም ጥሩ ነገር ያገኛሉ እድሮች ደግሞ ይረዳዳሉ የተጎሳቆለች እናት ካለች ይረዳሉለ ለድጋፍና እንክብካቤ ያደርጋሉ፡"

Aynalem added that if someone requests help, *idir [kere]* is willing to provide financial and technical support during wedding, christening, other events or medical emergencies. With the spread of HIV, Alem indicated that *Idir [kere]* has even changed their bylaws to increase members' monthly contribution in order to support orphaned and vulnerable children in their community. Alem added "community based associations understand the challenges and needs of

mothers better and create a collaborative atmosphere, thus they play a significant role to enhance maternal health” “ማህበራት ለናቶች ጤና ያላቸው ሚና ከፍተኛ የተሻለ ነው በመተገዙም ያለውን ችግር መረዳቱም በማወቁም በኩል ቡና ጠጡ ቡድኖች የተሸሉ ናቸው”

Meseret discussed the importance of being a member of *Idir* saying

> *idir* is so important. I am a member of two *Idir*. God forbid, if a child or a mother or a father die, *idir* provides all the support including emotional, labor related, as well as financial support. In addition, if I or my child gets sick, I can borrow money from my emergency savings and use it. Then I can pay it back when I recover.
> ሰንበቴ እንጠጣ ነበር አሁን ግን አቅም ሳጣ አቋርጫለሁ 5 አሞት ጠጥቼ አሁን አቋርጫለሁ፡ ፡ እድር አለን እኔ ራሴ 2 ቦታ ነው ያለኝ እድሬም ይጠቅማል ለምሳሌ አያርገው እንጂ ልጅ ይሞታል እናት ፣ አባት ወንድም፣ ሊሞት ለማስተዛዘኛ ይሆን በተጨማሪም እኔ ወይ ልጄ ብንታመም አክሲዬን ስለለን ያን ብር አውጥቼ እጠቀማለሀለሁ ከዛ ሰርቼ ብሩን መመለስ ነው

Hizbe also highlighted that *Idir [Kere]* plays an important role for mothers especially those who are in labor and needs to go to the health facility by coordinating volunteers or members who can carry her on stretcher beds. She said “a number of men are needed to carry a woman in labor to the health facility since she has to be carried on a stretcher bed [locally made of wood and hide]. Thus, even if she has no relatives, Kere recruit volunteers to carry her” “ያው ሰዎች በርከት ብለው በእንጨት ፣ በአውሳንሳ - አሰተኝተው ነው የሚወስዷት ዘመድ እንኳን ባይኖራት ቅሬ የሚባል ነገር አለ። በሱ የግድ ነው ይወስዷታል” Emama Halima explained community support as essential part of maternal health services that are available. She said

> It is the community that support each other! Government don’t have enough resource to support everyone. Government educate community members and tell you to have prenatal checkup and may provide nutritional support for very few selected mothers. But the real hands on support is from the community [cooking, cleaning, feeding, accompanying…etc].
> ህብረተሰቡ እርስ ብርሱ ነው እንጂ የሚረዳዳው መንግስት ከየት አምጥቶ ይረዳል መንግስት ያው ያስተምራል እንጂ ሰው ነው እንደቅዋው ልጅንም ጎረቤቱንም የሚንከባከበው።

መንግስት ያው ስልሽን ተመርመሪ ብሎ ት/ት ይሰጣሉ ለልጆች የክሱ የከሱትን መርጠው ምግብ ይሰጣል እየመዘነ

In the same manner *Mahiber* and *Senbete,* associations that are affiliated with the Orthodox Christian church based associations are also identified as sources of psychosocial and financial support for mothers who are members as well as outsiders. These associations are also important platforms where women exchange information.

Mente said "I have Mahiber called St. Michael. If any member gets sick, we contribute money and visit that person. If s/he needs money for medication, we all contribute and give the required amount" "አዎን ሚካኤል ማህበር አለኝ የማህበር አባል ቢታመም አዋጥተን የተያዘውን ይዘን ጠይቀን እንመጣለን፤ ወይም ይህ ያህል ህክምና ያስፈልጋል ካለ አዋጥተን እንሰጠዋለን። እድር አለኝ ግን እሱ ሰው ሲሞት ነው የሚረዳው"

Tsige added "there is Senbete in every neighborhood. Whenever there is an event they exchange information. Any information. If someone is pregnant and experiencing complications, her colleagues tell her to go to the health facility and get checkups" "ሰንበቴ በየጎጡ አለ - ሰፋ ያለ ነው። በዛ ሰዓት ይናበባሉ። አንዷ የሰማችውን ለአንዷ፣ ነፍሰ ጡርም ሆና ችግር ካለ ከከለ ሄደሽ እንዲህ እንዲህ በይ ጤና ጣብያ ብትሄጂ እንዲህ እንዲህ ነው ራስ በራሳቸው ማለት ነው"

Hizbe also confirmed saying "In my Mahiber, we contribute money and set it aside for any emergency. If a member is short of money to get medication, we use the emergency money to help the person in need. We help each other" "እዚህ ደግሞ አሁን የማርያም ማህበር አለ። እዛ ብዙ ግዜ ብር ይዋጣል ይቀመጥና ሰው ቢታመም በፍጥነት ለማሳከም በተለይ ብር የሌለው ከሆነ ብር እርስ በራስ ይረዳዳሉ ማለት ነው።"

In addition to the financial support, Bethel said, associations provide physical and psychosocial support.

> If a mother is sick or if she needs help, any kind of help, her association is the first to responde; whether she is delivering or she is throwing a wedding party. For a woman in rural village, her community is her primary support. Her community, her neighbors are the ones who get her to any medical facility since she has to be carried in a stretcher bed. (Bethel)
> በተለይ ደግሞ ስትታመም ቀድመው የሚደርሱላት እነዚህ ማህበራት ናቸው። ብትወልድም ብትድርም እነሱ ናቸው። ገጠር ላላች ሴት ማህበረሰቡ ከፍተኛ አጋሯ ነው። መንግስት ተቋም ላይ አንኳ የሚያደርሳት ማህበረሰቡ ነው። በአልጋ ተሸክሞ ምን ብሎ የሚወስድ ጎረቤት ማህበርተኛ ነው።

These social gatherings are also used to discuss challenges within the community and come up with shared solutions in an informal but powerful settings as it allows women to share their experience, to voice their needs and be aware of developments in her community.

> *Mahiberat* raise mothers' awareness in many ways. Mothers who participate in social gatherings are much progressive and aware than mothers who stay at their house, since those mothers have access to information and different experiences (Bethel).
> ማህበራት የናቶችን ንቃተ ህሊና ከፍ የሚያደርግ ይመስለኛል። ምንያቱም እቤት ውስጥ ታፍና የምትውል ሴትና ማህበራት ለይ የምትሳተፍ ሴት ትለያለች። ወደ ማህበር ስትሄድ የልምድ ልውውጥ ይኖራል አንዳንዳ ነገሮችን ታገኛለች።

2. <u>Policy-Led Facility-Based Maternal Health Services in North Wollo</u>

Research participants identified available facility based services for mothers, how the services are delivered, the level of service utilization, the challenges and gaps in the service delivery. I also observed various health facilities within the community which ranges from health posts that are located in every *kebele* [smallest administrative unit—neighborhoods], health centers in *Woredas,* [larger towns- collective of different neighborhoods or provinces] and the referral *Zonal* hospital, *Woldia Hospital,* which is the only hospital serving the population including mothers, from all over *North Wollo*. Except for small towns and cities, almost all facility based services are delivered by the government free of charge.

These facilities deliver pre and postnatal care, which included: vaccination for mothers, pregnancy checkup, nutrition counseling, expected delivery dates (EDD) calculation, delivery, postpartum care, vaccination for newborns, and family planning. Except for delivery, most of these services are available at health posts stuffed by health extension workers.

The health extension workers I interviewed told me that they conduct home visits, identify pregnant women, and provide them prenatal care connecting them [pregnant women] to the formal health system. Health extension workers do not deliver babies but they encourage and sometimes accompany mothers to the nearby health center.

Mistre confirmed that there are health extension workers in every *kebele*. She said

> No woman should stay hiding in her house. Hence, we conduct home visits and find pregnant women. We inform the local development group (government cadres). They [the development group] bring them to the health post, where they would get health education. Then, they will start their checkup and be told to go to the health center to deliver their babies. If a mother knows a neighbor who is hiding, she will be able to convince her and bring her to the health facility. Her husband will also be informed in order to facilitate the access and utilization of the health facility. The moment she start having contraction, community members will carry her to the health center on stretcher bed.
> ሁሉም ቀበሌ ላይ የጤና ኤክስቴንሽን ሰራተኞች አሉ 1ቲም እናት እቤት ውስጥ መቅረት የለባትም ስለዚህ ቤት ለቤት ይዞራል በዚህ ወቅት ነብሰጡር እናቶችን እናገኛቸዋለን። ለልማት ቡድንም ይነገራል ስለዚህወደ ጤና ኬላ ያመጧታል የጤና ት/ት ተሰጥቷት ትሄዳለች ሌላ ሰው እንኳን ጎረቤቷ ተደብቆ የሚኖር ካለ ያቺ እናት እንድታመጣት ትሆናለች። ስለዚህ ያው ክትትሉን ትጀ ምራለች ምጥ ሲይዛት ጤና ጣቢያ ትመጣለች እናም ሁሉም ቦታ መልክቱ ይደርሳል።

Hirut said “we [health extension workers] work at the health posts. We provide vaccination, family planning services and first aid. We also promote the 16 health packages”

“አዎን ጤና ኬላ ነው። ጤና ኤክስቴንሽኖች ናቸው ያሉበት 1ኛ የክትባት አገልግሎት 2ኛ የቤተሰብ ምጣኔ አገልግሎት 3ኛ First-aid እንሰራለን - 16ቱንም የጤና ፓኬጆች እንሰራለን”

Then, she added:

> If we found a pregnant woman [during home visits] we inform her to get prenatal care and to give birth at the health center. After she gave birth, she will have follow up after 3 days, 7days and 6 weeks. If all women follow these routine, then we could make a difference in maternal health"
> በምትወልድ እና ከሆነች በስርዓት የቅድመ ወሊድ ክትትል እንድታደርግ በምትወልድበት ወቅትም በጤና ጣብያ እንድትወልድ ት/ት እንሰጣለን ከወለደችም በኋላ፤ በወለደች ቀን በ3ኛና በ7ኛ ቀንና በ6ኛው ሳምንት ክትትል ይደረጋል። ይህን አደረግን ማለት በናቶች ላይ ጥሩ ለውጥ አለ ማለት ነው…

I also asked health extension workers to reflect on policy led facility based services as mothers and community members, in addition to as a professional providing community based care. Tsige said "I started working as a health extension in 2005. There are so many changes from then to now. The community is more aware about the importance of facility based care. We [HEWs] are also getting better at providing care and support since we have more knowledge and experience". "በኛ አቅም አለ ከበፊቱ ይሻላል። እኔ ኤክስቴንሽን ሆኜ ተመደብኩ 97 ነው ከዛ ጅምሮ አሁን ሰው እየገባው መጥቷል። ደህና ነው። እኛም ራሱ ለናቶች ያለን ርህራሄ በጣም ጥሩ ነው። ትምህርት ማህበረሰቡ ከመውሰዱ የተነሳ እኛም (HEW) ከማወቃችን ከመረዳታችን የተነሳ ለውጥ አለ።"

Other research participants also confirmed that they use most of the services provided by health extension workers in their community. Birhan said "I do use the services in the health post. It is free and I will go there every three months to get the injection [Depo-Provera shot]. The service is good and they give you the pills based on your choice" "አዎን እጠቀማለሁ ጤና ጣቢያ ነው። ነፃ ነው ግልጋሎቱ በየ3 ወሩ ትሄጃለሽ ተወግተሽ ትመጫለሽ ሰርቪስ ጥሩ ነው መድሃኒቱን የሚሰጥሽ አንቺ በመረጥሽው ነው ይስማማል አይስማማ ብለው የሚያደርጉት ነገር የለም "

Minte added:

> Health extension workers advise pregnant mothers to have regular prenatal checkups from the very beginning. Therefore, we will go to the health post every month for our regular checkup. And when we are there they treat us well. Then

> we give birth at health center. If we give birth at night we will go home the following day, and if it is in the morning we will go home around dusk.
>
> እናትነት እንግዲህ ሲረገዝ ጀምሮ እስኪወለድ ድረስ ሲረገዝ የጤና ኬላ ሂደን ተከታትለን ገና ሀ ብሎ ሲጀምር ጤና ኤክቴንሽኖች እንዲህ ማረግ አለባችሁ ብለው ይመክሩናል ከዛ በተመከርነው መሰረት በየወሩ እስከ 9 ወር ድረስ ለምርመራ እንሄዳለን በ9 ወር ገና ምጥ ስንያዝ እንሄዳለን እነሱም ነፍሰ ጡር ነው የሚያስተናግዱን በደንብ በስርዓቱ ነው የሚያስተናግዱን እንወልዳለን በስርዓት ፅዳት ይጠበቃል ከዛ ማታ ከወለድን ጠዋት እንወጣለን ጠዋት ከወለድንም ማታ ውለን እንወጣለን

Zebenay highlighted how situations are changing overtime for mothers saying

> Before, we give birth at home with the help of traditional birth attendants. Today, it is different. The government provides care for pregnant mothers. There is prenatal checkup, they give us medication and deliver our baby.
> ወልጄ ስተኛማ ያው ጎረቤቶቼ ያዩኛል ቤተሰቤም ካለ ያው በደንብ ይንከባከቡኛል ድሮ እንደዛሬው ጤና ለም በራሳችን ነው የምንወልደው ፊት ወልደን ያው አዋላጅ ያዋልደናል እንደዛሬው አይደለም ዛሬ ግን መንግስት በደንብ በየ15 ቀኑ እርግዝናችንም ይሰጣሉ። ብንወልድም ደግሞ በደንብ ይመረምራሉ እራሳቸው ሞላ ጎደለ ብለው ያያሉ።

Research participants also mentioned that they are more comfortable with health extension workers since they are all women who could better understand the biological and sociocultural challenge.

Delivery is provided in health centers which are located in the nearby towns. The distance and time to get to health center varies depending on mothers' access to transportation and the topography of their location. There is an ambulance service for transporting mothers to get to the health center and/or the hospital if there is any complication.

Zebenay pointed out that the development group representative will call the ambulance the moment they are informed. If the location of the mother in labor is not readily accessible, community members will carry mothers on stretcher bed to the ambulance. Selam confirmed saying "the moment she starts having contraction, we [development groups] will be notified and make a phone call to the Woreda health office and they will send the ambulance" "ከዛ ቅናቸው

ከታወቀ በህዋላ በ ፱ ወር አንቡላንስ ይላካል: ይደወላል እኛጋር ቁጥሩ ስላለ: ስለዚህ ፱ውሯ ሞልቶ አመመኝ ደከመኝ ስትል እንደውላለን:: ወደ ወረዳ ይደወላል አንቡላንስ ይመጣል ወደ ኡርጌሳ ይሄዳሉ- ከዛ ደግሞ ሪፈርተብሎላቸው ወደ ወልዲያ ወልዲያ ይሄዳሉ።"

Meseret, Zere and Desta also pointed out that the ambulance will take mothers to the health center to give birth, and if there is any complication the ambulance will rush them to *Woldia* Hospital.

The national health policy promotes facility based birth forming new and using existing community based structures to implement this goal, through sanctioning homebirth, and organizing various training and awareness raising programs for community leaders and elders who can influence behavioral change in mothers' health service seeking behavior within their community. Bethel confirmed that traditional birth attendants are restricted from assisting homebirth since they do not have enough science based knowledge to identify complications in time and handle emergencies. Traditional birth attendants do not also have the necessary tools such as gloves to use in delivery. Tayche mentioned "these days, mothers give birth in health facilities since homebirth is sanctioned. If a mother gave birth at home and got discovered, she will pay 500birr and the birth attendant will also pay another 500birr". "አሁን የለም። ሁሉም በቅጣት ገደብ ስለተባለ እዛው ጤና ጣቢያ ነው የሚወልደው የአዋላጅ 500 የምትወልደው ቤት የሚወልደው የለም"

Tsige also discussed they used trainings to promote facility birth as follows:

> We organized HIV/AIDS training for religious leaders and traditional birth attendants. This training highlighted risk related to homebirth, including HIV infection and hemorrhage. We also told them that they will be held responsible if the baby or the mother die during

birth. If they are aware of this risk, they will start referring mothers to health facilities. But if the mother lives in inaccessible far places, it is hard to refer mothers to health facilities.

ባለፈው ከሃይማኖት አባቶች ጋር ልምድ አዋላጆችን ሰብሰባ ጤና ጣብያ ስልተጠና ሰጥቷል። እነሱም እንደሚታመሙ በHIV ዙሪያ ሴትዬዋ ብትሞት ተጠያቂ እንደሚሆኑ ጤና ጣብያ ወስደን አሰልጠነናቸዋል። ያው ማዋለድ እንዲተውና ወደ እዚህ እንዲልኩ ማለትነው። ምጥ ተይዛለች ኑልን ሲባሉ ቶሎ ብለው ለጤና ኤክስቴንሽኗ እንዲነግሩ HEW ደግሞ ወደ ጤና ጣብያ እንድትልክ ነው ያሰለጠናቸው ነገር ግን የቦታ ርቀት አሁንም ይገድባል።

Sinidu also confirmed that the government is forming community-based structures to recruit cadres and promote the national health policy which is focused on facility based birth.

Then she said:

The care and support for mothers start within her household. Then neighbors and friends come along to provide support. I am a member and a leader of a community based structure called 1 to 5 development group[7] which provide trainings to members to raise awareness and mobilize the community. I was a traditional birth attendant for more than a decade. But now I am a member of homebirth eradication committee. Thus, if I see a pregnant woman I tell her to get prenatal care and to give birth in a health facility. As a group that belongs to the community we [members of 1 to 5 development group] also visit and assist mothers who are pregnant or sick in their household. We also gather information from other groups if there are pregnant mothers in their community who didn't have prenatal care, and if there is we go to her house as a group and educate her. Thus, there is support for mothers at every level starting from her household to the structure.

አንደኛ አካባቢ ሁኔታ መጀመሪያ ከቤት ይጀምራል። እንክብካቤው ቆይታ ከጎረቤት ነው። ከዛም ባልንጀራ ጓደኛ ይቀጥላል። ከዛም ደግሞ እኛ ተደራጅተናል እ/ር ይመስገን 1/5 የልማት ቡድን አለን ከዛ ት/ት እየወሰድንነው። ስለዚህ እኛ እርስ በርስ እየተከባከብን ነው ያለነው። ነፍሰ ጡ እና ካለች እኔ አሁን የልምድ አዋላጅ ነኝ። በድሮው ማለት ነው። አሁን ደግሞ የቤት ውስጥ ወሊ አስወጋጅ ኮሚቴ ነኝ። የ1 ለ5 ቅም ምሪ ነኝ። ይሄን ስል ደግሞ ነፍሰ ጡር እናቶችን ብቻ ሳይሆን የታመሙች እናትንም እንከባከባን። እናት በመሆኗ ማለት ነው። ነፍሰ ጡ እና እንከብካቤ ያስፈልጋታል ቅድመ ወሊድ አለ፣ ድህረ ወሊድ አለ ክትትል ታደርጋለች ወይ ብለን የ 1 ለ5 ቡድኖችን እንይቃለን። ከናንተ ነፍሰጡር እናት አለች ወይም ክትትል ታደርጋለች ውይም ሄዳችሁ ጠይቃችኋታል ወይ ብለን እንጠይቃለን ከቤት እንክብካቤ ጀምሮ እስከ ልማት ቡድኑ ድረስ እናት እንክብካቤ አላት።

[7] 1 to 5 is a community based development structure that is formed under the structure of the government. It is a group of 5 members with one leader in every neighborhood. There is women's as well as men's group. 6 groups will then be clustered under one general leader who is considered the 'administrator'. The groups report to line government offices in their administrative units and considered development actors or allies for any social development programs.

Adding to governments effort to promote facility birth birthing, Kinde said that the health facility in *Beklo Manekia* has allowed family and community members to carry out some rituals within the facility after delivery. “when a woman give birth at the health facility we make genfo and have coffee ceremony. The neighborhood will contribute through their development group and get all the ingredients ready” “አንዲት እናት ጤና ጣብያ ስትወልድ ገንፎ ይገነፉላታል ጤና ጣቢያው ማለት ነው እቤትም ስትገባ የማርያም መሸኛ ተሰብሎ ይዘጋጃል ጤና ጣቢያ ገንፎ ለማገንፋት በየልማት ቡድኑ በየአደረጃጀቱ ተዋቅሮ እህል ይዋጣና የማርያም መሸኛ ግፎ እህል ይዘጋጃል”

In small towns I have observed small private clinics run by health officers or nurse practitioners mostly provide general services. I have never encountered clinics that provide delivery service. Research participants also mentioned that they go to private clinics to get Depo shots, which can run in short supply at health posts due to the larger demand.

Summing up, Bethel reflected on facility based maternal health services saying “Compared to the past, the current situation is much better. The government created networks to reach women in every community. Having health extension workers in every kebele, and making contraceptives available for women is a great start to enhance maternal health”. “ከበፊቱ ጋር ሲነጻጸር አሁን ያለው ጣም ይሻላል። ጅማሬው ጥሩ ነው መንግስት የዘረጋው network በጣም ጥሩ ነው። በየአካባቢው በየቀበሌው ጤና ኤክስቴንሽን ፣ መኖሩ FP ማግኘታቸው ጥሩ ነው HEW ራቅ ሲል ማዋለድ መቻላቸው ጥሩ ነው።”

When participants discuss about maternal health needs and maternal health services they discussed it holistically. Their explanation was not only focused on medical needs during pregnancy, birth, and after birth. Their major focus was the emotional and socioeconomic needs and supports. They highlighted the importance of easing the household work burden of mothers

and accompanying them through the process of birth and during the 40 days after birth, assisting in basics day to day activities such as cooking, cleaning, collecting firewood, fetching water and managing the household. The traditional community based services and the spiritual values placed on motherhood and helping new mothers allowed mothers to recuperate their physical and emotional strength, after going through the traumatic experience of giving birth.

VI. FINDINGS CHAPTER III. GAPS IN MATERNAL HEALTH CARE

Research participants reflected on the gaps in policy lead facility based maternal health services as well as community based maternal health care. In these process they pointed out various traditions and beliefs that influence health service seeking behavior of women who require medical services in general, including: general health checkup and treatment, as well as reproductive health.

A. Beliefs and Traditions Affecting Facility Based Health Service Seeking Behaviors of Mothers

1. Perception of Birth and Death

Research participants identified birth and death as a natural phenomenon. Birth is part and parcel of being a woman and death is part of being a human. Based on her experience as a traditional birth attendant for more than 34 years, Emama Tenagne said “all the births I assisted are the same. All mothers give birth the same way…. She added “The difference in facility birth is the additional support a mother may get if her labor is hard or if she experiences hemorrhage. For mothers who deliver normally, it is the same everywhere—just cutting and securing the umbilical-chord.

> እንደው እኔ በየሄድኩበት ናሁሉ አወላለድ የሚለይበት ነገር የለም: ሁሉም አንድ ነው! ልዩነቱ ሃኪም ቤቱ ደም ቢፈስሽ መድሃኒት ይኖራል በዛ ላይ ምጥ ሲጠና እርዳታ ሊኖረው ይችላል። እንጂ ንጽህ ለሚለወዱ ሴቶ እቤትም የምታረጊው ያው ማዋለድ ነው እትብት ማሰር ነው ሃም ያው ነው። አሁን ግዜው ደህና ሆኖ ሆፕራሲሆን ሆነሽ በ3 ቀናት ነው የሚወጣው እኔ አንዷን ልጄን ሆፕሬሽን ሆኜ ነው የወለድኳት ልጅ ስለነበርኩ ማለት ነው 9 ቀን ነው የተኛሁት ከአላማጣ መኝቼ ማለት ነው።

Emama Fate also confirmed “in the past traditional birth attendants were very knowledgeable. They would assess the fetus using their fingers and if it is breeched they correct the position. That is how we reproduced and get to where we are now”. “ነበሩ አዎን በደንብ

ጥንቅቅ ያሉ ቢዞርም ቢወላመም የሚያዩ የሚመረምሩ በእጃቸው እንዲ እንዲች አድርገው አሸት አሸት ሲያደርጉ ትክክል ይመጣል ልጁ ቦታው የሚመልሱ ነበሩ በግዚያቸው በወቅታቸው ቀደም ባለው ሰዓት እንደዛ እየሆንን እየተራባን ኖረናል እኛም"

Hizbe also explained "mothers strongly believe that they can give birth at home without any complication, with the support of God. And for most mothers, homebirth has no consequence. So nobody attributes harm or death to homebirth". "እቤት በሰላም እንገላለግ እንጂ ጌታ ይደግፈን እንጂ እዛ ሄደን እዚ መጣን ልዩነት የለውም። ብዙ ጥቅሙን አያውቁትም። እቤት በመውለዳው ጉዳት የሚደርስባቸው ብዙ የሉም ከስንት አንድ ነው። ስለዚህ ጉዳት የለውም ብለው ያስባሉ።" Shewa added "… for the community here birthing is the same, whether you do it at home or at the health facility. And, if death is to happen, no one can stop it. Therefore, mothers prefer homebirth and the help of traditional birth attendants". "እቤታቸው እንደሆናችሁ ብትወልዱም ትወልዳላችሁ፡ ባትወልዱም ሞት እንደው አይቀርም ለምን ህክምና ትሄዳላችሁ? ስለሚሉ ያቸው በባላገር ወጌሻ ነው የሚወልዱት"

The notion of death as destined has significant influence on mothers' health seeking behavior. This notion is confirmed by almost all of my research participants despite their academic background or professional experience. Selam boldly said *"*if it is the destined day, people die" *"*ቀኑ የደረሰ ግን ይሞታል።" Emama Halima added "*Allah* is the only keeper of life. Mothers die [in health facilities] even leaving their twins, if it is her day, no one can do anything about it." "አዎን መንታ ልጅ ወልደው እየሞቱ ነው ያሉ! ምን ታረጊዋለሽ? አሁንም ይሞታሉ: እንግዲህ ሃጅሯ ከደረሰ ምን ደረጋል?" Sereke also confirmed that she knew mothers who died in health facilities as well. Then she explained this notion based on her experience saying

> I gave birth at home with the help of my neighbors. Those days were ok. There was no health center and fear of HIV/AIDS. The experienced women would measure and cut the umbilical-chord, pick up the baby and cleaned it. Then, the mother will sleep and recover. However, people go to health facilities these days. But if you are meant to die, doctors cannot rescue you from death no matter how hard they try.
> አይ ብቻ አይወለድም ግን እኔ በወለድኩበት ሰዓት ሁሉ ነገር እንደዚህ አልተጋነነም። በሽታው አልተጋነነም። እኔ ደግሞ አልያም --እስካሁን ድረስ በጤና ነበው ያለሁት እኔን ጎረቤቶቼ ናቸው ያዋለዱኝ ያጠበውም ደፋር የሆነእ ለክታ ምን ብላ ቆርጣ ልጁን ታነሳለች ከዛ በኋላ መተኛት ነው አሁን ዳግሞ ያው ሃኪም ቤት ቢኬድም ይሄ ሃኪም ሞት ከመጣበት ከሞት አያድንም ግዜ ገና ከሆነም ሴትየዋ ታክማ ትመለሳለች ደሞ የመኖት ቀኗ ካልሆነ የፈለገ ቢንከባከባት ከሞት አትድንም

Birhan also added that birth related complications or death are attributed to fate. Even medical mistakes are attached to fate hence, there is no serious accountability for doctors. “እንዲህ አይነት ሞት /ጉዳት ሲከደት ግን ሰው የሚያስበው ያው እድሌ ነው ብሎ ነው። ቀኗ ደርሶ ነው የሚባለው እጂ የሃኪም ስህተት ነው አይባልም። “

2. <u>Spiritual Indications</u>

In addition, other traditional beliefs and spirituality influence mothers service-seeking and utilization. Most mothers who perceive that they are possessed by a spirit will not use ‘modern’ health facilities. Explaining this point Hirut, a health extension worker, said “some mothers do not want to get vaccination when they are pregnant because they assume injections are opposed to their ‘spirit’. “ዛር አለብኝ ምናምን ብለው፤ አንደናዶቹ ዛር አለባቸው፤ በቤታቸው የሚያደርጉ ማለት ነው፤ ክትባት ተከትቡ ስንላቸው ዛራችን ይነሳል ይላሉ::” Meseret also confirmed that mothers, especially in far rural neighborhoods, tend to attach everything to spirits and they reject anything new or foreign to their cultural practice. Sinidu also added “some women carryout different rituals that are related to spirits, thus they avoid health facilities. But these days this influence is diminishing through awareness raising and education” “ደሞ ቤታቸው የቤት ጣጣ

የሚባል አለ - ዶሮ የሚያዙሮ አሉ፤ መረግ የሚስብሉ አሉ። ያው በት/ት እየጠቀረፈ መጣ እንጂ አሁን ይሄ ችግር ነበር።"

3. Access to Health Facilities

Research participants raised lack of easy access to health facilities as a major gap in maternal health care. Even if there are health posts in rural village they do not have the resources to fully provide the required services, hence they refer patients to the nearest health center. However, health centers are located in major towns that are far from rural villages. The limited access to transportation adds to this problem.

Hizbe said "if there were a health facility nearby, pregnant women would get services easily. Nobody would have been left out due to the distance and inaccessibility." "እዚህ አካባቢ የተሟላ ጤና ኬላ ቢኖር ነፍሰጡር እናቶችን በቀላሉ ህክንና ያገኛሉ። እርቆናል ብለው የሚቀሩ አይኖሩም አያውቁንም ብለውም የሚቀሩ አይኖሩም።" And Zebenay added " the problem is that we don't have health centers nearby. There is no place to go when we are sick. The health posts are doing their best but it is not enough." "It is also very difficult to carry mothers who are in labor and walk on these hills [pointing at the hills] for 3-4hours" (Misre). For some places (Worke in Kobo Woreda, for example), the driving distance is about 60kms (one way) which could take more than 2 hours given the poorly paved zig-zag road. Therefore, people do not want to take the risk. Hence, mothers who can come to the health facility, but those who cannot will stay home.

4. Obstructions in Health Facilities and Service Delivery

The other important factor identified by research participants is mothers' lack of trust on the service of the health facility. Most community members perceive health professionals to be incompetent and unprofessional. And, health facilities have stringent rules and regulations that

are conflicting with the culture and tradition of the community. In addition, most health professionals who assist delivery in health centers and hospitals are men. All these situations push mothers away from using health facilities.

All research participants confirmed that mothers do not want to be nude and exposed in front of men; however, the professionals who assist birth are mostly men. Aynalem said *"it is a shame to be undressed in front of men"*. ጤና ጣብያ ላይ ያሉ አዋላጆች ወንዶች ናቸው:: ለወንድ መታየት በጣም አፍረት ነው":: Fenta added *"no body likes to be exposed in front of men, hence they prefer women". "*አዎ በወንድ ፊት መከፋፈቱን አይወዱትም ከወንድ ይልቅ ሴትን እንዲመርጡ ነው የሚነገሩት"

Deliberating over mothers' trust of health facilities, research participants raised issues related to overall competence and professional ethics. Shewa said "mothers do not trust the health facility. They associate health facilities with unnecessary c-section and medical mistakes". "ያው ቡዙዎቹ ኦፕሬሽን ትሆናላችሁ፣ ሃኪሞች በጓነት እየገቡ ያበላሽችኋል እንደዚህ ይባላሉ"

Desta further explained

> Health facilities could be scary for mothers since women are afraid of being naked in front of stranger men [midwife and interns]. In addition, they always want their sister or mother to be with them in the labor room but it is not allowed. Traditionally women never be left alone in a room while in labor, as it is believed they would be exposed to evil spirit. Moreover, birth is natural.
> ሃኪም ቤት ስንድ እዚ አገር ያው የተሸፋፈነ ነገር ነው ፍርሃት ይኖራል። ያለሃኪሙ ማንም የሚገባ የለም ግን አብዛኛው ሰው ዶክተር ብቻውን አይደል እህቴ ትግባ እናቴ ትግባ የሚባል ነገር አለ። በዚ አጋጣሚ ደግሞ ብቻችሁን ነው መውለድ የምትችሉት ስለሚሏቸው ያሳጡናል እዛ ሃኪም ቤት ሁሉ እናቶች አብዛኛው ምክንያታቸው እንደዚህ ነው እና ደግሞ የድንግል ፋንተራ እቤታችን እንወልዳን የሚሉ እናቶችም አሉ ለዚ ነው እንግዲህ

Aynalem also mentioned that mothers do not want to be examined by apprentices since they don't trust them. But if they go to the health center, mothers do not have an option to avoid students. For the students, she added, "it is important as practice makes perfect but for mothers it is not a good experience". "በዚያን ላይ ደግሞ ነርስ ተማሪዎች ይሳሳታሉ: ለተማሪዎች ልምድ አስፍላጊ

ነው:: ግን ለወላጅ መልካም አይደለም ደስ አይልም”. Ayda also added “There are mothers who died after going through various surgeries after birth since the doctor forgot something inside them—cotton, needle”. “ሌላው ኦፕሬሽን ሊያደርጉ በሃኪሞች ችኮላ ጎዝ/ መርፌ እየተቀውባቸው የሚሞቱ አሉ። ሁለት ሶስቴ እየተሰራላቸው በከተማም በገጠርም እንሰማለን። “

Emama Tenagne explained the faults in facility birth further saying

> Doctors may kill. Because they follow their education. But their instinct is important. Labor is like flood. It is not always predictable. We [traditional birth attendants] sit with the mother from the beginning to the end. But doctors cannot sit with the mother. They function within schedule. The other doctor has to change into his uniform and study the case… so anything can happen during the time in between [one doctor leave and another start].
> እንግዲህ ሃኪምም እኮ የሚገል አለ! ለምን ብትዬ በተማሩት ሳይንስ ሲሄዱ: - ምጥና ውሃ ሙላት አይታወቅም መቼ እንደሚመጣ እኛ ሲወልዱ ነው ብለው ምጥ ተያች ብለው አራጥቢታል ብለው ይወስዱናል ቁጭ ብለን እስኪመጣ ድረስ አነጋንም ዋልንም እናያለን ሃኪም 6 ሰአት ድረስ ከሆነ ፕሮግራሙ የሚሰራው ከዛ በኋላ ላንዱ አስረክቦ ይሄዳሉ። ያ ደግሞ ልብሱን ለብሶ ወዲያ ሽር ወዲ ሽር ሲል ቆይቶ ያቺ እናት አጉል ትሆናለች።

Selam mentioned that health posts and health centers may be closed some days. Even if the facility is open, she said “the workers don’t provide good service since they contend with each other”. “ እሱ አለ ቢኖሩም ግን እዛ የሚሰሩት ሰዎች ፉክክር እንጂ ተቋሙ አለ። ግን ሁልጊዜም ከፍተውት ከዋሉልኝ አገልግሎት አለ መንግስት ሰጥቶኛል። ምንድነው ትንሽ ያው 3 ናቸው ከፍተው መዋሉ ካለ ያው አገልግሎት አለ” Meseret also added that there is a significant problem in health facilities. She mentioned “There is shortage of medication. Even if the medication is there the professionals do not provide competent service. They don’t start work on time. And they don’t care if a person died. So the community is angry and sad.

> ሃኪም ቤት ላይ ችግር አለ መድሃኒት ሊቋረጥ ይችላል መድሃኒት እያለ እራሱ በትክክል አያክሙም ህዝቡን እያበሳጩ ህዝቡ እያለቀሰ ነው የሚሄደው እዚ ላይማ በጣም ችግር አለ እራሱ አንድ ሰው ታሞ መጥቶ እራሱ ስራ የሚገቡት ታሽተው ነው ሳይከም ቢሞት ጸጸቱ ለቤተሰቡ ነው እንጂ እነሱ እያሸካኩ ነው የሚውሉት ሃኪም ቤት ላይማ ችግር አለ

Hirut also confirmed that shortage of medication, necessary amenities and professionals is a major challenge for HEWs to provide quality service to the community. She added “I can only do so much in my capacity and if it is too much, it is hard to provide quality service and welcome patients with a smile”.

> ጤና ጣቢያ ላይ የማይሟሉ መሳሪያዎች ሊኖሩ ይችላሉ። መንግስት አልጋውንም ባለሙያውንም ቢያሟላ ጥሩ ነው። በጀትም በቂ አይደለም ወረዳ ላይ እራሱ ይሄ ችግር አለ፡ ፡ ከእንግዲህ ሁኔታ እናቲቱም በደህና አትስተናገድም ዛሬ አሁን ፈገግ ብዬ ተቀብልኩሽ ጠዋት ላይብትመጪ 3ችንም ኮስታራ ነው የምንሆን የስራ ብዛት ስላለ። እናቶችን በሰላም አስተናግደን አንቺ ግን ብትመጪ ደሞ ምን ይዛብን መጣች ነው የምንልሽ የስራ ጫና ካለ የምትዋለደውም እናት ጥሩ ፊት አታገኝም። ጥሩ እንክብካቤ አይኖረም። ያቺም አመጣችብኝ ይችኛይቱም አማጣችብኝ ስንቱ ቦታ እሆናለሁ? ስለዚህ ይህን ነገር የሚያስተካክለው ወረዳው ነው።

B. <u>Gaps in Community Based Maternal Care</u>

Most of the gaps identified in community based care are related to the risks of home delivery and traditional birth attendants’ lack of preparation to identify and manage complications, if they happen. If any complications occur during birth, traditional birth attendants, who are the major actors in assisting homebirth, cannot do anything more than providing emotional and spiritual support since they do not have the necessary competency and tools to help women in unfavorable situations.

Selam identified the problem of using traditional birth attendants as:

> Traditional birth attendants massaged pregnant women and hold them upside down to correct the position of the baby. They also assist birth without gloves. In the past, it was ok to do all that. But now, there is the risk of HIV/AIDS, and a better way to assist birth in health facilities. Thanks to the Government we have a health center.
> ባህል ማለት እንደዚህ እንደዚህ በእጃቸው ይካካሉ፣ ቂቤ ያሻላሉ ነበር እንዲህ አኛ ህፃን ሆነን ማለት ነው እናቶቻችንም ሲዋለዱ እናያለን ይዘቀዝቃሉ ምን ይላ፤ ጓንት ሳያረጉ ያዋልዳሉ ። ግን እንደግዜውና እንደሰዓት ሲዋልዱ ምንም ችግር አልፈጠረባቸውም በኋላ ላይ ግን ከት/ት ጋራ በሽታውም መጣ። ያው አሁን ግን እየተሳተፉ ነው በሽተኞቹ እራሱ ንፁህ ልጅ እየወለዱ ነው በጤና ጣቢያ ማለት ነው። አሁን ደህና ወቅት ነው የዛ ሰዓት ግን እነሱ ት/ት ስለሌላቸው ስለማያውቁ ጤናማ ደህና ናቸው። አሁን ግን እንዳፋችን ሆኖ የኛ ግዜ አይደለም በሽታውም

እና ጋር መጣ። ጤና ጣቢያው በረካ ይን ግን መንግስት ጤና ጣቢያ ስራ እኔ በሽተኛም ብሆን ጤነኛ ንፁህ ልጅ እወልዳለሁ ይህን አመሰግነዋለሁ።

Other research participants also added that complications may occur after birth depending on the position of the child and the strength of the mother. Community members, including traditional birth attendants will not be able to save the lives of mothers if she has complications during delivery such as: eclampsia, hemorrhage, baby suffocation, breeched birth, prolonged labor, retained placenta, prolapsed uterus, except taking the mother to the health facility. This complication cannot be controlled by traditional birth attendants.

Mulu said "I don't like homebirth. I have experienced it. I have a problem of bleeding and it is a lot of hassle to clean up after delivery. There is nothing appealing in homebirth. But in health centers, it is all clean". "አይ እኔ እንደው ቤት መውለድ ምንም አይጥመኝም አይቸዋለሁ እኔ አሁን ደሞ ይበዛብሻል እቤት ያን ደሞ ምን ያረጉታልማጠቡ ምኑ ኧረ እንደው ደስም አይል። ሃኪም ቤት ግን ጽዳት እንዳለን ነው።" She added "mothers could face complications if they give birth at home. The baby could be breeched, they may suffer from hemorrhaging, fistula could happen, the child could be suffocated. Womanhood and motherhood is loaded with the unexpected." "አዎን አሉ እቤት ሲወልዱ ጉዳት ይደርስባቸዋል። ምጡ ያለ አይነቱ ሲመጣ፣ ብዙ ደም ሲፈሳቸው እነዲው በሴት እኮ ያለውሃ ብዙ ነው ፌስቱላ አለ በተለይ ያለ እድሜ ጋቻ ካ፣ ልጆቹ ታጥፈውም ይመጣሉ።"

Birhan also mentioned

> In health facilities especially hospitals, they can use forceps to pull the baby, they will give labor inducing injection (pitocin/oxytocin), and perform cesarean-section. But in home delivery injury could occur—especially when mothers lose their strength to push during labor and birth assistants try to pull the baby out. I have a friend who suffer from this problem [prolapsed uterus].
>
> ከወሊድ ጋር እንግዲህ ሃኪም ቤት እንኳ ስትወልጂ የምጥ መርፌ ተሰጥቶሽ ከሆነና አቅም ካነሰሽ ልጆቹን በሚጎተቱበት ወቅት ማህፀን ላይ ችግር ይፈጠራል። ማህፀን ወደ ውጪ የሚወጣበት ሁኔታ አለ የማውቃቸው ሴቶች አሉ በዚህ ሁኔታ ላይ ያሉ።

Another drawback identified in community based care was the influence of socioeconomic status in the level and quality of care a mother gets from her neighbors and community members after she gave birth: i.e. when she is *Aras* – the 40 days after birth. Research participants identified that even if the neighborhood cooperates and cares for new mothers, the quality of care during the 40 days after birth which includes the food she eats, is dependent on the socioeconomic status of the mother and her family. Aynalem strengthened this point saying

> If a new mother has money and support in the house she will be cared for from 3 to 6 months. Bur if she is poor she will start household chores after a week or two. If there is no support in the house, we would start working after two weeks. Or sometimes, we work at night and go back to our bed during the day, and pretend as if we don't do chores when neighbors and friends visit.
> 3ወር-6ወር ድረስ እናት በስርዓት ትታረሳለች ጢስ ትሞቃለች እቤት ሰው ያላቸው ደህና ገንዘብ ያላቸው ቤተሰብ ካላት ካልሆነ ግን ያው ደሃ ከሆነች በሳምንቷ ተነስታ ምጃ ልትገባ ትችላለች እኛ ራ እኮ ገንዘብ እያልን ሰራተኛአጥተን በ15 ቀን ተነስተን የምንሰራበት ወቅት አለ አንዳንዱ ደግሞ ሌሊት ስንሰራ ቆይተን ቀን ምንም እደልሰራ ሰው መኝታችን ላይ ቁጭ ብለን ሲጠይቁን ከሞጡ ጓደኞቻችን ጋር እናወራለን

C. Supply Vs. Demand: Visual Expressions

All participants acknowledged that maternal health services in their communities are much better than the past. They identified that there are available resources to mothers providing prenatal and postnatal care; and mothers have a better option to utilize facility based delivery. The presence of an ambulance is also encouraging and facilitating the conditions for facility birth. However, participants also identified that the ambulance is not reliable due to various infrastructural problems. Unreliable mobile networks, shortage of gas to run the vehicle, inaccessible roads are some of the identified problems. In addition, participants also identified that the incompetence of traditional birth attendants, the spread of HIV/AIDS, and sanctions on homebirth makes maternal health complicated issue for community members. These circumstances complicated the decision for homebirth as well as facility based delivery.

However, when research participants compared the need with the supply, there is a substantial disconnect. Participants represented this big gap using various sized rocks, stone beads, bottle caps, and household and farm tools – Shovel and spoon.

Figure 25: maternal health demand vs supply: pictures from visual dialogue

Several research participants represented demand vs. supply using different sized rocks – bigger rocks representing demand while the smaller ones representing supplies with the smaller ones. And they explained that the smaller rocks represent the needs being only partially met. Examples used by several of them were the demand for contraception and supplies. Most mothers in community use and want to use Depo-Provera shots, however due to the larger demand there is usually a shortage. Hence, women are forced to go to a private clinic that cost them money, or replace it with pills or other longer term contraceptive that is available in health posts.

Figure 26: maternal health based demand vs supply: pictures from visual dialogue

D. **Summary**

Thus far, I have presented the findings in relation to the first four research questions: 1) how do mothers define their need? 2) To what extent have their needs been met? 3) What has helped the most? And 4) what are the gaps, if any? In response to these questions, research participants eloquently defined motherhood, identified their needs, available maternal health

services and the gaps in the services. Examining the responses, the influence of cultural norms, traditions and rituals is clearly visible. Cultural norms, traditions and rituals influence their conceptualization of motherhood, the foundations of community based services, maternal health service seeking behavior as well as service utilization.

The next chapter presents research participants' reflection on the final section of the research question: what do mothers think would improve their situation?

VII. FINDING CHAPTER IV. MATERNAL HEALTH: HOW CAN WE ENHANCE IT? AND WHO IS RESPONSIBLE?

This section is focused on research participants' deliberations and recommendations to enhance maternal health and minimize maternal mortality in their community, and considerations on who is responsible to enhance maternal health. The major themes identified in these deliberations include promoting awareness raising and community based collaboration platforms to address issues related to maternal health; helping women get economic independence through technical and financial support; addressing major infrastructural gaps that contribute to psychosocial and physical health of mothers; and improving access, reliability, and service quality of existing health facilities. Participants also held the government as well as every member of the society responsible for contributing to these needed changes. This section also includes my reflection on my personal experiances as a woman and a mother, and the deep conversation it engendered with one research participant during the interview.

These recommendations and reflections are explained in depth as follows:

A. "Bringing women out of their kitchen"

Research participants indicated that women have to be able to participate in community awareness raising events to get access to new information related to their health. Traditionally, women avoid public events especially those that include men. And honestly, women do not have time to participate in long events since they are always occupied with household chores, raising children, attending social events in their neighborhood [wedding, funerals, birth, religious and other celebrations], visiting and caring for the sick and elderly in their neighborhood, as well as seasonal field work. Tradition also requires them to be passive than assertive, to be considered a 'good women' or 'good wife'. Thus, as Aynalem eloquently laid out "we need to bring women

out of their kitchen", so that they can participate in awareness raising and mass education platforms which would equip them with the necessary information to make better decisions about their health and wellbeing.

> The government provides health services. However, even if these services are available, the women are still in hiding at their home. Most of them are not using the services. There is a good start in terms of contraceptive use such as Depo and pills. However, most women come to get this services hiding from their husbands. There is also a good beginning in use of prenatal checkups and facility based delivery. But it is just the beginning! We need more! (Aynalem, Women Affairs representative in Kobo Woreda)
> በዚህ አካባቢ ለናቶች ይህ እንክብካቤ እየተሰጠ ነው ማነው የሚሰጠው የናቶችን የጤና ሽፋን የሚሰጠው መንግስት ነው ነገር ግን እነዚህም አገልግሎቶች ቢኖሩ ሴቶች ገና ከጓዳ አልወጡም ጥሩ ጅምር አለ ግን ለምሳሌ ፒልስ እየተጠቀሙ ነው። ግን ይህን ነገር የሚጠቀሙት በባልየው እውቅና ነው ይሄ ያጠያይቃል ተደብቀውም የሚመጡ አሉ ለሌላው ደግሞ ጤና ጣቢያ ላይ ሄዶ የመውለድ ጅምር አለ። የቅድመ ወሊድ ቼክ አፕ አለ ግን ጅምር ነው ሰፋብሎ የሄደ የለም

> A mother, as an autonomous individual, has to take steps to get her medical checkups and follow up her health and wellbeing. Then, she can share the benefit she gets with her neighbors and be exemplary (Hisbe, Health extension worker)
> እናት ደግሞ እንደ ግለሰብ ለጤናዋ ክትትል ማድረግ አለበት፤ ያገኘሁትንም ጥቅም ለሌሎች ለጎረቤት፣ ለሚጠይቀኝ ማሳወቅ አለብኝ ለምሳሌ መሆን አለብኝ/ አለባት።

> There is education and information out there. But mothers have to be out there. They have to participate in community events and use the services (Mulu, Community member).
> "ት/ት በደንብ አለ አሁን እውቀት አለ ያው እናቶች መጥተው የግድ ግልጋሎቶት መውሰድ አለባቸው"

All these quotations from community members with different academic and professional background shares one important thing in common—the need for women's autonomy and a safe space where mothers can freely participate. Otherwise, as those wise women put it, the availability of a service does not guarantee its utilization.

The interviews also revealed that women do not have access to assets and capital even if they constitute more than half of the population in North Wollo. Legally, women are entitled to

half of their household assets after divorce. However, while they are married they are dependent on their husband. And as mentioned in the paragraphs above, many women have no up-to-date information due to their limited access to mass education platforms or public media [no electricity, they spend most of their time out in the field or working around the house], and most women cannot read or write. They also have limited access to make money since they are stay home mothers, which makes them dependent on their husbands.

> Most mothers are very poor. Even if we say they are doing well financially, the wealth is controlled by their husbands. They face emotional abuse. Physical abuse is also still there. Solving the problem of psychosocial and physical abuse on mothers is very complicated. It may require the coming generation to step up. We always say it's getting better because we compare it with the past. But, women are still economically dependent on their husbands (Alem, Program coordinator in an NGO).
> ፍላጎታቸው ተሟልቷል ማለት አይቻልም። አብዛኞቹ እናቶች በዝቅተኛ ንሮ ደረጃ ላይ ያሉ ናቸው ያላቸው እንኳ ቢባል ያለው የሃብት ቁጥጥር በወንዶች ስር ነው እና በወንዶች ስር ነው እና በወንዶች ፍላጎት ላይ ዬተመሰረተ ነው የስነልቦናው ጫና አለ፣ አካላዊ ቅጣቱ አለክቀረም አሁን ደህና ነው ቢሉሽ እንኳን የሚያወሩትና እቤት ያለው ሲታይ በጣም የተለየ ነው አካላዊ ኢኮኖሚያዊ ስነልቦናዊ ጫና የናቶች በቀላ የሚፈታ አይደለም ምናልባት ከዚ በኋላ ያለው ትውለክድ ሊፈታው ካልቻለ በስተቀር ከባድ ነው አሁን የተሸለ ነው የምንለው ከድሮው በማነጻፀር ነው ግን ስታየው በኢኮኖሚ ሴቶች ጥገኛ ናቸው በአብዛኛው

Alem continued explaining women's current reality in North Wollo saying "for women who are more than 35 years old, the difference is not much whether you are employed or educated or not. Employed women can leave their house to go to work but most of them give their whole salary to their husband to manage it" "ከ35 በላይ የተማረው ም ሰው ብዙም ልዩነት የለውም የቤት ውስጥ ጫናው ያው ቢሮ ሲሄዲ ከቤት ይወጣሉ ግን ደመወዛበቸውን 5 ሳንቲም ሳያስቀሩ ለባላቸው የሚያስረክቡ አሉ"

I was quite struck on hearing this reflection. Even though I wasn't 35 yet, this narrative was a mirror reflection of my life as married women—employed, educated, giving my whole

salary to my husband [now my ex] to manage it, and often begging for some money from him when I am in need. It was fascinating to hear and point out similarities across cultures, despite the difference in educational and socioeconomic status; or whether one is from big cities or living in a small rural town. Being a woman nurtured within similar traditions and Christian based norms [for many] was a common denominator. I could not hide my mixed emotions from Alem, my interviewee at that point, who noticed and asked "are you ok?". Even if it is a very awkward moment for a 'researcher' to be asked that question, it was a moment of truth for me. I definitely broke down into tears and start confessing my life story to this amazing, wise woman.

Revealing myself to that level changed our relationship for good. We had a very honest discussion about being a woman and womanhood, mothers and motherhood, the challenges we face, the contribution of traditions in keeping the status quo where women are expected to be submissive to their husband and traditions. We shared our upbringing, our journey as a woman thus far. For her it included raising 5 children—her nieces and nephews—even if she never wanted to marry or have a child of her own, after her sisters died of HIV/AIDS. Her struggle to 'fit in' as a 'woman' since she never liked anything 'girly'. As a child she recalls how happy she was: never dressed as a girl—her father picked her boys cloth, everyone in her neighborhood addressed her as a boy, and she always was with her dad outside doing boys chores. But once puberty hits, things start changing and she started having encounters from peers in high school and then college, which was in a major city. After college she decided to return back home taking a job as a teacher in a very rural village, where everyone is comfortable with who she is. Now, she is a very respected member of her community, known for her hard community based work in the entire North Wollo Zone. At the age of 50, she still goes to men's barber shops and wears men's pants and sneakers with full confidence. And she is a proud mother who raised

very successful children. This discussion was very helpful and even therapeutic for both of us to talk about our struggles and achievements in life.

The other important point that was mentioned by research participants was the importance of educating women and girls to ensure their access to information and secure their autonomy. Aynalem explained: "Women in this community are disadvantaged because they are 'illiterate'. They cannot read and write; and they don't have any access to information. Thus, they have to be educated." Even if education is the key to empowerment, it is a long-term plan. On the other hand, women's needs, especially health needs, require immediate response. Mothers need venues where "she can voice hear opinions and needs openly to make a difference" (Bethel). Hence it is important to come up with contextual possible responses addressing their needs. The next recommendations highlight the possible ways to build women's autonomy and create conducive environment for women to voice their needs and utilize existing resources effectively.

B. "If they know they may even overcrowd the health facility"

Most research participants think that the community needs to know more about maternal health related issues, especially the risks related to pregnancy, delivery and postpartum so that mothers and families could make informed decisions. Health extension works believe that if the community, especially women, are taught about these risks, and benefits of prenatal care, they would use health facilities and "they may even overcrowd the health facility" (Hirut).

It is important to use existing social networks and associations such as *buna Tertim* [neighbors drinking coffee together], *Idir/ Kere, mahiber,* and/or *senbete*. Research participants believe that raising the community's awareness on maternal health related issues can be achieved if existing community based structures are used rather than creating a new community based

discussion group since women already have various traditional support groups they participate in. “Women support each other and solve their socioeconomic problems through their networks and social structures. They share their happiness and melancholy. They talk about their neighbors or families in need and how to support them; weddings that are coming up and plan how they could help” (Alem). Creating new groups would result in duplication of effort and splitting the scarce time women have to take part in social events. Thus, if one could work closely with existing groups to elicit and consider issues related to maternal health in their normal conversation, it would be possible to raise awareness in a cost effective and natural manner. It is also possible to bring sustainable impact since these structures have been, and will continue to be part of the community.

Given the infrastructural challenges, however, the community [neighborhood] needs to collaborate to get mothers to the health facilities. Without the support of a group of strong skilled men who know all the shortcuts and can carry mothers on stretcher beds, it is impossible to have facility based delivery. “Carrying someone on a stretcher bed and walking up and down the hill and crossing gorges is a very difficult task, and it needs dozens of men” (Misre). I got to the health post and then to the car after falling a couple of times since I had to climb a very steep hill which was full of dust and super slippery. I cannot even imagine how difficult and demanding it could be carrying someone, who needs great care—a woman in labor, and having to coordinate with other partners.

C. “Involve husbands in maternal health programs”

Enhancing the involvement of men in maternal health related issues is essential for bringing lasting change in the community. As explained in the above session, men control the decision making power in the household. Thus, any community based interventions have to

engage men even if they are not direct targets. Participants also mentioned that awareness raising campaigns and programs need to involve men since most part of the problem is related to men's lack of knowledge.

Men need to regard women as their life partners rather than their servants. "Husbands should consider wives as his equal and as his asset. This way he pays better attention to her needs" (Zebenay). Hence, changing their perception and raising their awareness on maternal health issues would benefit both women and men—the whole society".

> Men must be involved in awareness raising programs especially programs related to family planning. Many women use Depo shots over pills because they don't have to remember to do it every day. And many won't have menstruation during that time. But if they have their monthly period and don't get pregnant their partners would question why? So not having period is preferred for most since they use contraceptives hiding from their husbands…. We have raised women's awareness on the importance of using family planning thus far and they are determined to use it. However, it is hard to hide forever. Therefore, we need to work with men in the community since women cannot make a significant change without their collaboration. We need to involve husbands in maternal health programs! (Aynalem)

> ወንዶችም ደግሞ በግንዛቤ ማስጨበጫ ላይ መሳተፍ አለባቸው በተለይ ደግሞ ሰምተው አውቀው መተግበር እንዲችሉ መሆን አለባቸው ሴቶች ም ወንዶችም ምንም እንኳ መፃፍና ማንበብ ባይችሉም:: ሴቶች ዴፖ ይመርጣሉ አንድ ፒልስ ስለሚረሳ ነው:: 2ኛ ደግሞ ብዙ ሴት የወር አበባ ስለማያዩ ነው የወር አበባ ካየች ወንዱ ለምን አታረግዚም ብሎ ይጠይቃታል ካለየች ግን ችግር የለም በተለይ ተደብቃ ለምትወስድ ሴት; ስለዚህ አሁን በጣም የግንዛቤ ስራ መስራት ያለበት በወንዱ ላይ ነው ሴቷን ብናስተምራት ብቻዋን ምም የምታመጣው ነገር የለም።

Kinde also emphasized the importance of building men's awareness in issues related to family planning and maternal health to ensure sustainable change.

> Husbands and wives need to discuss and decide the best family planning options together. However, many women are using contraceptives hiding from their husbands. Hence, men need to know and understand the importance of family planning, its contribution to maternal health, and family wellbeing (Kinde)

D. <u>"It's all with your money and for your money"</u>

One of the most prevalent recommendation during the interviews was the importance of strengthening mothers' economy and financial contribution to their family. For most research participants having a sustainable income would help mothers to cope with psychosocial and economic challenges. Income provide mothers with some level of independence and the ability to take care of their health needs. If they have money, research participants argued, mothers can send their children to school, provide their children with the necessary stationaries, which provides them the emotional gratification for accomplishing their role as a mother; they can also get enough food for the family, and achieve a voice in family decisions [which include use of contraceptive, and selling and buying land, cattle, or a major furniture].

Strengthening women's finances also contributes to reducing poverty in the community. Poverty is a real challenge in most parts of North Wollo. People base their lives on subsistence farming which is highly affected by draught and famine as a result of weather changes or crop pests and diseases. Cash flow in the community is also minimal and community members cannot afford to pay for various services. Given this context, economic support is essential for mothers to stay healthy.

> Poverty is manifested in every spare of life in this community. People have no access to so many things because they are poor. They are challenged. If one gets sick, it's hard to recover since there is no solution in government health centers. But if you have money, you can go to private clinic and get a good examination. It's all with your money and for your money (Serke)
> ድህነት አለባት ሀገሪቱ በሁሉ ነገር አሁን በኢኮኖሚ የተነሳ ሰው ተቸግሮ ሁሉ ነገር እርቆት ነው ያለው፡ ሰው እየተቸገረ ነው አቅም የሌለው ሰው በአሁን ሰዓት ታሞ አይድንም። ምክንያቱም የመንግስት ሃኪም ቤት ሄደሽ የሚፈታልሽ ችግር የለም። ገንዘብ ካለሽ የግል ሃኪም ጋር ሄደሽ እንዲህ አርጊ ብሎ የተያየ ነገር ያዝልሻል ያው በገንዘብሽ ነው ሁሉም ነገር

Research participants highlighted that mothers can improve their life if they get the proper technical and financial support, access to markets, and training on financial

management. Women have sets of skills that can be mobilized and used to generate income. Therefore, Zere articulated: “it would be great if we could organize ourselves and get financial support to be engaged in income generating activities. In a support group we would work hard to sustain and improve our life” “ማህበር ብታቋቁሙኑ የራሳችንን ስራ እንሰራለን ሴቶቹ ማለት ነው በስቁም ሆነ በምንም ንሮን ለማሻሻል ሰርቶ ለማደር ማትም ሆነ እናንተ ባላችሁት”. Alem also added: “it is important to educate women the importance of budgeting and saving so that they can lead their life smoothly” “እዚህ አካባቢ ያሉ ሴቶች እንግዲህ በንግድም በምንም ይሰማራሉ ግን የሚያገኙትን ገንዘብ በፕላን አይጠቀሙበትም ስለዚህ ት/ት መስጠት አለብን ከናቶች ጋር የተያያዘ አዲስ ቴክኖሎጂ ማስተዋወቅ አለብን ያላቸውን ቆጥበው በላቸው በአቅማቸው ኑሮዋቸውን መኖር ይችላሉ።”

During my observation visit, the only privately owned businesses in rural villages are public and goods transportation services [gari – horse carriage, bajajs, pickup trucks, minibuses and buses] and small kiosks that sell daily supplies such as cooking oil, salt, sugar (depending on the availability as it is very scarce), coffee (green beans), kerosene, charcoal, biscuits, candies and gums. However, I could not spot a bank or financial institutions, private clinic or private school, or a movie theatre. All health and education related services are provided by the government. The very few who could possibly afford to pay or who are desperate, need to travel to the city or major towns to utilize privately owned health and education services, which are presumed to have better quality. However, they need to plan their travel far in advance due to the infrastructural challenges.

E. Develop Basic Infrastructure

Without easy access to facilities, service utilization is unattainable. Hence the need for developing basic infrastructure such as road, electricity or other power supply, tele networks, clean water supplies, and flourmills within the community was highly stressed by research participants. The government provides ambulance services to encourage facility based delivery. However, if the roads are not accessible, or if it is difficult to reach the dispatcher over the phone due to bad telephone networks, this service is unreliable.

> those villages are really far. The ambulance cannot get into the village. There is no public transportation. It is only on contract bases which is very expensive hence mothers give birth at home. (Bethel)
> መንገዳቸው በጣም ሩቅ ነው:: አንቡላንስም አያስገባም:: ስለዚህ ቤት ይወልዳሉ:: ትራንስፖርትም የለም: በጣም ውድ ነው ስለዚህ እቤት ይወልዳሉ።

> When mothers are in labor they will come to the health post. The health extension workers will call the ambulance and send them to health center. If the ambulance arrives in time it is good otherwise she will be carried to the health center and the ambulance pick her up on the road. (Zebenay)
> አሁን የለም ምጥ ከመጣበት እናት ጤና ኬላ ትመጣለች እነሱ የሚችሉ ከሆነ ያዋልዳሉ ካልሆነ ጤና ጣቢያ ላካሉ አሁን ተገኝ አንቡላስ አለች የተመደበች ይላክላታል ይዞ ይሄዳል ቶሎ አንቡላስ የማትደርስ ከሆነ በሰው በሽክም መንገድ ይጀምራል ከዛ ያው አንቡላንስ የደረሰባት ተቀብሎ ይዞ ይሄዳል።

Given this situation, participants requested the government and other collaborators to develop the basic infrastructure such as road, water, electricity, within their community. Developing basic infrastructure enhances the general wellbeing of mothers by significantly saving their time and labor as they are responsible for fetching water, collecting firewood, going to the flourmills or grinding at home.

Bethel eloquently explained this situation as follows:

> The work burden of a woman who gets water from her compound is very different from the one who fetch water from the river. Women who have electric baking appliances are different from women who use dried out leaves and branches to

bake. Hence fulfilling these basic infrastructures could make a difference for mothers.

አንዲት በጀርባዋ ውሃ ተሸክማ የምትቀዳ ሴትና ከቤቷ በር ላይ ውሃ በእጇ ቀድታ የምትጠቀም ሴት ጫናዋ ይለያያል። የመብራት ሁኔታ በእንጨት የምትጋግር እናትና በኤሌክትሪክ ምጣድ የምትጋግር ይለያያል። ስለዚህ እንዲህ አይነት መሰረተ ልማት ከመንግስት ቢሟላ የተሻለ ነገር ይኖራል የናትን ጫና ከመጠበቅ አንጻር ማለት ነው።

Selam added:

We don't have flourmills nearby. For pregnant women, carrying hot flour that is just out of the flourmill and traveling long distance because there is no road and no transportation is very bad. It is the cause of the problem [since it induces abortion]. We need a flourmill and road in 014 [Kebele administration].

ስለእናት በጎይ ምክንያ ማለት ነው፤ ከእናት ሞት ሙቀት የሚቀንስ ለምሳሌ መፍጨ ቤት የለንም እሱ አንድ ጣውንት ነው ወፍጮ አስፈጭቼ ስሄድ መስመሩ እሩቅ ነው መንገድ አልገባም ሙቀት ተሸክሜ ነው የምገባው። አንዱ የእናት ሞት እሱ ነው። እሱን ዪቀንሰው ይሄ ቢጨመርልን ደህና እንሆናለን የምለው ይሄ ነው አንዱ ወፍጮ ቤት ቁ 14 ወፍጮ የለንም፤ መንገድ፤

F. <u>"If it is not as good as my house, what do I do there?"</u>

One of the major concerns on facility based delivery service was the reliability of health facilities. Most health facilities do not have the proper amenities and supplies, and courteous and ethical staff. To be fully functional health centers need to be welcoming and well equipped. They need to have sufficient beds, medical supplies, up to date equipment and adequate professionals. However, my research participants as well as my field observation indicate that most health centers in North Wollo would not pass any standard examinations, if there were any.

Most health centers are new buildings. The maternal health wards in most health centers do not have enough bed—only one delivery bed and another one waiting room bed, and no ultrasound. Health extension workers and health officers use pinard horns[8] for prenatal checkups. They also measure pulse using their fingers and their watch. In the six health centers I visited, all

[8]Unlike in the US, Pinard horns are still commonly used in developed European countries in preference to Doppler monitors. They are considered more accurate and practical, less expensive, and safer alternative to the Doppler device, which picks up tones that can be further from the heart.

the midwives are men except for one women. And the staff members tend to be overwhelmed and snappy. Hence, there is almost nothing appealing and attractive for mothers to use the health center.

Figure 27: Pinard horn

Hirut, a health extension worker explained the challenges in health facilities honestly as:

> Health centers need so many updated gadget and supplies. The government need to provide more beds and professionals. In the current condition, it is so hard to provide service. you see me now with a smile on my face, but if you were here earlier in the morning I was grumpy. The work load is too much! If there are three women in labor at the same time how can I serve them? Thus, when professionals are overwhelmed they cannot serve with a smile. They are more frustrated. Hence it should be corrected.
> ጤና ጣቢያ ላይ የማይሟሉ መሳሪያዎች ሊኖሩ ይችላሉ። መንግስት አልጋውንም ባለሙያውንም ቢያሟላ ጥሩ ነው። በጀትም በቂ አይደለም ወረዳ ላይ እራሱ ይሄ ችግር አለ፡ ፡ ከእንግዲህ ሁኔታ እናቲቱም በደህና አትስተናገድም ዛሬ አሁን ፈገግ ብዬ ተቀብልኩሽ ጠዋት ላይብትመጪ 3ችንም ኮስታራ ነው የምንሆን የስራ ብዛት ስላለ። እናቶችን በሰላም አስተናግደን አንቺ ግን ብትመጪ ደሞ ምን ይዛብን መጣች ነው የምንልሽ የስራ ጫና ካለ የምትዋለደውም እናት ጥሩ ፊት አታገኝም። ጥሩ እንክብካቤ አይኖረም። ያቺም አመጣችብኝ ይችኛይቱም አማጣችብኝ ስንቱ ቦታ እሆናለሁ? ስለዚህ ይህን ነገር የሚያስተካክለው ወረዳው ነው።

Kinde, another health extension worker who was trained to provide delivery support at the health post said that she cannot deliver children. “You see, this is the only room I have and the delivery bed is right there upfront. So I can’t do paperwork and delivery in the same room”. “ይዤ ነው የሚሄደው ጤና ኬላ ላይ አንድ አልጋ ብቻ ነው ያለን ግን አንድ ክፍል ናት ቤቷ ስለዚህ ማዋለድ አይመችም”.

Debre, another health extension worker who got the training also confirmed that she cannot provide delivery services at the health post because she doesn't even have enough gloves. The only available supply in the health post was umbilical cord ties.

> I only delivered one baby in this facility since I don't have basic materials. I am also scared. If a mother died while I was helping her, it will cause much more harm. The community will always associate the health facility with death. And they will always question my ability to deliver any service. I will lose all the love and respect. Thus, I provide prenatal care, child vaccination and refer mothers to health centers for delivery. It is tough (Debre)
> እኛ እናዋልድ ብንል እራሱ ደም ብዙ እንዳይፈሳት የሚወጋው መርፌ የለም፣ ጋንት (glove) የለም። የሚገርምሽ እትበት ማስሪያ ብቻ ነው ያለው ስለዚህ እዚህ ማዋለድ አልችልም። አንዲት ልጅ ብቻ ነው ያዋለድኩ እስካሁን እኛ እንፈራለን እናዋልዳለን ብለን ይቺ ሰው እ/ር አያርግባትና ብትሞት ከጥቅሙ ጉዳቱን ነው አርሶ አደሩ የሚያየው ወደፊት ዳግም ይቺ ምንድናት? አትችልም ብለው ክብራቸውም ፍቅራቸውም ይቀንሳል። ስለዚህ እኛ እዚ ጤና ኬላ ልጆችን እንከትባለን፤ ቅድመ ክትትል እናረጋገለን እንጂ የሚወልዱ ጤና ጣቢያ ነው በፊት delivery ስልጠና 1 ወር ይሰጥ ነበር፤ አሁን ግን የለም። ስለዚህ አስቸጋሪ ነው፡

Tsige [health extension worker] also pronounced her concern on the very structure of the health post clinic. "this building is so small and ugly. The floor is mud and dust. There are rats, plenty of them. They usually mess the medication. And those cracks [pointing at them] can hide snakes". "የጤና ኬላው ቤት ውበት - ሲያምር ይስባቸዋል። እኛ አሁን ገብተን እራሱ በጣም ይቦናል። ለመጥረግም አይመችም ፣ አይጦች አሉ ብዙ መድሃኒት ዳርድረን መድሃኒቱን ይበሉብናል። መሬቱም ጭቃ ነው ቤቱም ጭቃ ነው ቤቱ ለይስሙላ ነው የተሰራው የተሰነጣ በቂነው አውሬ ይደብቃል እንኳን ማህበረሰቡን እነሱን እኔንም አይስበኝም"

After hearing about snakes I couldn't sit still in that health facility. The health post and health center are very close to each other- about 10-minute walk. Thus, I visited the health center on my way. The walls and floors are cracked. Those cracks can hide rats, lizards, and definitely snakes. I was scared to death to walk outside. The facility nurse—who is a gentleman—walked

me to the car. Clearly a city girl, but my fear is legit. Snakes as scary as they are, could be poisonous.

Mothers are also worried about the sanitation of the facilities. In my field observation I also noted the hygiene and sanitation of health centers was concerning. The rooms and equipment are dusty, the bed sheets are stained and old, the waiting area is a mess- cracked long wooden chairs.

Figure 28: chairs in waiting area of health facilities- taken from google images

Health posts do not have public latrines. In most health centers the latrines are locked and the ones that are open are malodorous even to pass by. "If the health facility is clean and attractive, providing good service everybody will go. But if is it not better than my house, what will I do there?" (Alem). The authorities blame this situation on the shortage of water and sanitary supplies in the health facility.

In addition to the need to have clean and comfortable health facilities, Ayda mentioned, "whether patients know a staff in the health facility or not; whether they are rich or not everybody should get quality service".

Getting quality health service from health facilities was the desire of mothers in North Wollo. Similarly, health extension workers and community members believe that quality service is the core for attracting mothers to facility based deliver, thereby minimizing the risk for maternal and infant mortality.

> If we [health professionals] provide good service people will use it. No mother will give birth at home. But we need full equipment and the government has to provide it (Debre)
> እኛ ጥሩ ሰርቪስ ከሰጠን የተሟላ ነገር ካለን፣ ማህበረሰቡ ይመጣል ማንም እናት እቤት አትወልድም፤ የምትወልድበትን ነገር ማሟላት መንግስት አለበት። ሁሉነገር እዚህ ቢሟላ - አሁን ተገኝ ከመሄድ እዚሁ በአጥቢያቸው ይወልዳሉ

> The major thing for the community, even better than making 'genfo' in the health center, is getting quality service from health facilities. what attracts mothers to health facility is the presence of up to date equipment and competent, courteous, and ethical professionals. There are professionals who slap patients—if they scream loud during labor, and get away with it. They are not even questioned. These are not professionals. They have to be fired. If mothers get quality service, they will use health facilities (Bethel).
> ገንፎ መገንፋቱ ጥሩ ነው። ግን ተፅዕኖ ያለው አይመስለኝም። ዋናው Service በጥሩ ሁኔታ ማግኘታቸው ነው። እቤታቸው ሲገቡ አገንፍተው ይበሉታል። አገልግሎት ነው ወደ ጤና ጣቢያ የሚያመጣቸው የተሟላ ዕቃዎች ባሉት በተሟላ ባለሙያ መውለድ ጥሩ የሆነ አቀራረብ ያላቸው የሙያ ስነ ምግባ ር ያላቸው ሰዎች ማዋለድ አለባቸው አንዳንዴ እኮ ማን አባሽ ከፈች አለሽ? ብለው በጥፊ የሚማቱ ባለሞያዎች አሉ። እንዲህ አይነቱን አስወግደው ጥሩ አገልግሎት ከሰጧቸው እናቶች ጤና ጣብያ ይወልዳሉ።

Research participants raised a very important concern on the ethical and moral grounds of some health professionals working in health centers and hospitals. Licensed nurses, health officers, laboratory technicians and medical doctors can have their own private clinics and/or pharmacies. Hence, health professionals usually open private clinics in small towns and cities, and are there on a part-time basis. Many of the professionals who have private clinics are accused of using government based health facilities for recruiting customers. They usually order [unnecessary] lab tests, or prescribe medications and refer patients to their private clinics.

> Health professionals should give due attention to maternal and child health, the overall mission and value of their health institution. However, if you assess the situation, most professionals serve based on the benefits they get and their ego. They are not really functioning based on their oath to their profession. We need professionals who serve for the mission and values than for their pay checks (Alem)

ግንዛቤያቸውን የተሻለ ደረጃ ላይ ከደረሰን ያው ባለሞያ ለህጻናትና ለናቶች ትኩረት የሚሰጥ መሆን አለበት። በአብዛኛው ስታይው ከግል ጠቀሜታ አንጻር እንጂ የቃልኪዳናቸው መሰረት አይደለም የሚሰሩት አንዲት እናት ተቸግራ ስትመጣ የሷ ችግ ከውስጡ ሊሰማው የሚችል ባለሞያ ነው የሚያስፈልገው እንጂ ስለሚከፍለው ብቻ የሚሰራ ከሆነ ያቺን እናት ችግሯን ሊፈታላት አይችልም፡

Research participants also recommended improving the poor pharmaceutical supplies in health facilities and upgrading health posts and health centers to better serve the community. They also mentioned that health facilities that provide delivery service should be open 24/7 including weekends and holidays since mothers can be in labor anytime on any day. Moreover, the midwives in health facilities need to be women to be provide culturally appropriate services to mothers. It could also be more beneficial if close relative or a friend is allowed in the delivery room so that mothers "don't feel that they are left alone in the delivery room while the service provider leave to check on another patient. Labor in itself is traumatic enough for mothers" (Desta). It is perceived in the community that being alone during labor could expose mothers and their babies to a wicked spirit.

After visiting health centers and even the hospital [Woldia Hospital], and talking to mothers, I was questioning myself if I would like to use these facilities to give birth. My answer to this critical question was: NO! I would have to be out of options or desperate to consider those facilities.

G. <u>"Traditional birth attendants should be trained and equipped"</u>

Traditional birth attendants are one of the most important actors in maternal health and community based maternal health support. They are the first one to know whenever a mother in their neighborhood is labor. They could also be the only support during delivery whenever there is homebirth. Therefore, research participants argue that "traditional birth attendants need to be trained and fully equipped" (Bethel).

> Whether they are really good or not, they will help in delivery when they are called to save life. Hence, it will be beneficial if traditional birth attendants get the necessary training and the full delivery kit. In Region 1 (Tigray), traditional birth attendants have sterilized kit with all the necessary first-aid materials including gloves. Thus, they go to help mothers fully equipped (Aynalem, Women Affairs representative)
> የልምድ አዋልጆች በጣም ጎበዝ ባይሆኑም ኧረ እባክሽ ሞተች! ሲባል ማዋለድ የግድ ነው የልምድ አዋላጆች ሙሉ ትጥቅ ቢኖራ ቸውና ቢያዋልዱ ይመረጣል በተለይ እሩቅ ቀበሌ ላይ በተለይ አሁን ክልል 1 ላይ ሁሉም በስነስርዓት መሳርያ አላቸው: ግዋንት አላቸው: ስለዚህ ያንን ይዘው ልክ ክትባት እንደሚሰጡ ባሞያዎች ሊያዋልዱ ይሄዳሉ፤ ድንገት ከሆነ

Other recommendation by research participants include: better contraceptive choices, support from private sectors and non-governmental organizations. The contraceptives that are available have various side effects that are mostly not treated or not considered. Health extension workers provide most of the services related to contraceptive choices and family planning. There is no prescreening, no blood tests or anything before starting contraceptives. The options are also limited. Even if side effects are reported after use, health extension workers have neither the capacity, nor the resources to treat side effects or change the medication. This situation leaves the women to decide either to live with the side effects or stop the medication and face the consequences. Therefore, it is important to have more contraceptive options for women to scale down the side effects.

As I mentioned earlier, there are no private clinics in rural villages and towns. The absence of basic infrastructure [electricity, telephone networks, transportation and so on] in rural settings will make running private clinics very expensive and stressful. Therefore, more collaboration from other sectors such as NGOs is very important since the government is the only maternal health service providing sector. Therefore, “it would be great if there are other organizations that promote maternal health and have interventions to minimize maternal mortality” (Debre).

H. Who Is Responsible to Enhance Maternal Health?

Responding to this reflective question, most research participants stressed that everyone is responsible to enhance maternal health. However, they argue that the government has to take the leading role to achieve this end since it has the authority and the potential to make a difference. Despite all the pitfalls, Emama Tenagne recalls the days the previous regime launched a country wide program which trained traditional birth attendants and how that regime created safe space for mothers. “we had a hut called “Wezero Mamite” where we provided delivery services for mothers while getting all the necessary training. That training was my foundation. During those days, mothers got the care and support they needed. We don’t have that now”. Therefore, the government needs to create conducive environments for all stakeholders: community members, women, health professionals, and other support organizations, to collaborate and function towards the common goal—enhancing maternal health and minimizing maternal mortality. Participants also highlight that developing basic infrastructure such as roads, electricity, telephone networks within the community will also increase access and utilization of existing resource.

> Mother is the foundation of a family, she has compassion. If she is not around, every family member including the husband and children will fall apart. Thus, ensuring maternal health is everybody’s responsibility (Kinde, health extension worker)
> እናት የሁሉም መሰረት በመሆኗ ነው እሩሁህ ና የቤተሰብ አስተዳዳሪ ናት እሷ ከሌለች ቤተሰቡ በልመና ልጆችም መበተናቸው ነው ያለው ስለዚህ እናትን መንከባከብ ግድ ነው እሷ ከሌለች የተወለዱት ልጆች ወደ ሌላ ቦታ ይሄዳሉ፤ የጎዳና ተዳዳሪ ይሆናሉ: የሁሉም ሃላፊነት ነው :- ባለሞያው አመራሩ ህብረተሰቡ
>
> It is everyone responsibility, it’s mine, it’s yours and the nation’s at large. Would there be a child without a mother? If there is no mother, it is impossible to have a future, a generation. My son, if I die, there is no one to care for him, to pay for his school, hence, he will end up on the streets. He will be a problem for the country. Therefore, mothers should never die (Birhan, Community member).

የሁሉም ማህረሰብ የኔም፣ያንቺም፣ የሃርም ነው እናት ከሌለች ልጅ ይኖራል እዴ እናት ከሌለችኮ ነገን ተረካ የሚሆን ዜጋ ማፍራት አይቻልም የኔ ልጅ እኔ ብትሞትለት እኔን ካጣ የሚያስተምር ሰው ላይኖር ይችላል የት ወድቆ ጎዳና ላይ በይ ለሃገር ሽክም ሆነ ማለት አይደለም ስለዚህ እናት መሞት የለባትም በምንም ይሁን በምንም

A mother is like a nation. Thus maternal health cannot be a responsibility of one sector or one program. Mothers are for all. There are mothers in every household. Every part of the community has to participate (Bethel, Nurse)

የሁሉም ነው። የማህበረሱም የመንግስትም የሁሉም ነው እናት ሀገር ናት ስለዚህ ለአንድ ወገን የሚተው አይደለም በጋራ ሕብረተሰቡ መሳተፍ አለበት መንግስትም የሚዘረጋው የራሱ ኔትወርክ አለው። እናት የሁሉም ናት፣ በየቤቱ ናት ያለችው ስለዚህ ሁሉም መስራት አለበት።

Everyone is the result of the society and socialization. Therefore, the community is responsible in shaping and nurturing children in a way they become beneficial to the family, the community, and the nation at large. These children are the policy makers (Ayda, community member)

“ማህበረሰቡ ደግሞ ልጆቹን አንጸ ማሳደግ አለበት። ለማህበረሰብ ለቤተሰብ ለሃርም እንደጎጂ አድርጎ ማሳደግ አለበት። ያው ሁሉም ከማህበረሰቡ ስለሚወጣ”

The notions in each of these quotes, despite the academic and professional differences of research participants, has a common theme, i.e. everybody is responsible to enhance maternal health and minimize maternal mortality. These responses can also be linked to the first section of this chapter where motherhood is defined. If a mother is considered as the foundation of a society, then, everyone has to collaborate to ensure her wellbeing. However, if she is considered just as an individual person, it is up to her to keep up with her health. By holding every member of the society responsible to enhance maternal health and minimize maternal mortality, research participants re-acknowledged the conceptualization of motherhood as a fundamental role, and maternal health as a collective gain than a personal benefit for individual mothers only.

VIII. DISCUSSION AND IMPLICATIONS

The purpose of the research was to examine the interface between maternal health policies and grassroots communities in Ethiopia and evoke culturally competent policies and programs. To this end, four primary research questions were examined through in-depth, semi-structured interviews and visual dialogues with 28 women who are living in North Wollo Zone, Ethiopia: 1) How do the mothers, who are intended to benefit from maternal health policies and programs, define their needs? 2) To what extent have their needs been met? 3) What has helped the most? 4)What if any gaps remain, what do mothers think would improve their situation? The overall research was guided by Indigenous methodologies that require relationality and multilayered reflexivity (Nicholls, 2009). Nicholls (2009) identified three layers of reflexivity (p. 121)—self-reflexivity, interpersonal reflexivity, and collective reflexivity.

According to Nicholls (2009) self-reflexivity involves the researcher's reflection on their bias and their awareness of their power and privilege in the research process, through identifying what ideas to include or exclude in their research. Carryout this research I have continuously reflected on my bias, power and privilege, starting from the interview guides, and continuing through transcribing and writing up the findings. However, the process of self- reflexivity has not been an easy challenge. Transcribing and coding were the most difficult part of this research since I developed more and more personal and emotional ties with my research. Listening to the interviews, transcribing and coding surfaced a lot of my own personal challenges as a 'mother'. I continuously questioned my understanding of motherhood, my place in my children's life as a mother, and my career path. I gave birth to a girl and a boy who are now fifteen and nine respectively. My children are in Ethiopia, while I am here in the US pursuing my PhD. Hence, technically I am not mothering them. Then, am I a mother? What is my social status as a mother?

Can a mother have her own career, what would it look like? Would my perception of motherhood influence my analysis? Am I capturing my research participants fully? Those are the questions I have been dealing with as I finish writing my findings chapters. When the emotions are hard to deal with I will stop working on my research for days, weeks and even months at times, and seek out help from my colleagues – especially my Ph.D. cohort.

Interpersonal reflectivity calls for an evaluation of interpersonal encounters and the researcher's ability to collaborate with others, examining how the researcher's identities intersect with institutional, geopolitical and material aspects of the community they are embedded in along the research journey (Nicholl, 2009). Lastly, collective reflexivity entails questioning the process of how the collaboration determined the frames of inquiry, examining the terms of participation, and what effects did this participation have on the outcome of the research (Nicholls, 2009). My familiarity with the community helped me to understand cultural nuances and unspoken truth. I was able to understand the unbalanced socioeconomic position of women, the pain involved in child raising due to poverty, the cultural expectation of motherhood that implicitly calls for enduring domestic abuse, and sacrificing for the sake of children. My understanding of these nuances helped me to easily build relationships with gatekeepers and my research participants. Therefore, most interviews were very deep. Collective reflectivity also asks whether the underpinning theory of the research is relevant to findings or not. The use of structural social work within the framework of Indigenous methodologies is very relevant to the findings of this research.

Therefore, through the three layers of reflexivity, this research ensures research participant's voluntary participation and self-determination, rendering their voices throughout the

research process. Member-checks were also used to ensure the findings are the representations of their voices.

The first section of this chapter examines the results of this study in relation to each research question and connects these findings to Indigenous methodologies and structural social work. In the later section, the implications of these findings will be identified and discussed in light of maternal health policies and practices as well as implications for social work education and future research. The limitations of the study will also be discussed in the last section of this chapter.

A. Results Analysis

1. Motherhood and Maternal Health Needs

As Pettigrew (1987) reminds us our perceptions influence and guide our action. Hence, the way we perceive motherhood influences how we define and act on maternal health needs. With this in mind, research participants were asked to define motherhood before we started discussion of maternal health needs, which is the central research question.

In their definitions Mothers included women who gave birth to a child; raise or help raise a child; female teachers who guide students through academic knowledge as well as discipline; older women who are respected and share their wisdom and blessings to the community; spiritual leaders (Nuns, *Duberties)* who are considered spiritual bearers of the community; and traditional birth attendants who help deliver children at home. Examining this definition, motherhood is expressed through the lens of performativity (Butler, 1994) magnifying the act of mothering, i.e. nurturing and serving children as well as the community more than the biological function of giving birth to a child. Hence, mothering provides women a desired social position within their community and the opportunity to fulfill their social and cultural roles as women. Research

participants also visually represented mothers and motherhood using various metaphors: mirror – a reflection of the past, the present and future; breath – essence of existence; pillars – tying a household together and stronger; *warka* – providing safety and protection from threats; flower – beautiful and yielding seeds that would be the fauna, the coming generation; earth or ploughed land – patient, and always giving without complaint until the last drop. Such representations magnify the importance of mothers to their children, their household, as well as to the nation and society at large.

Most research participants indicated that they understood the depth of motherhood when they became mothers themselves, raising their own children. They stated that the bond between mothers and children has no end even after death. They also affirm that nothing prepares you for the role of motherhood except experiencing it. Motherhood is also linked to selfless love, giving and nurturing. Motherhood embodies contrasting sides. On one hand it is a privilege, and on the other it is a sacrifice. The social status a woman achieves after she gives birth to a child or raises a child is significant. However, she has to pass through multiple challenges and fulfill traditional expectations while raising her child/ren, which include: fulfilling socioeconomic needs of children, enduring abuse and domestic violence.

> In this community, having a child is a place of privilege. And, having more children is always preferred. Children create more family and kinship bonds through marriage. The bonds through marriage create more social respect. Thus, the more children you have, the more respected and privileged you would be. However, if a woman has one child or didn't have a child at all, she would be stigmatized and considered selfish. (Alem)
> እንደ አካባቢው ወላድ መሆን ከፍተኛ ክብር አለው ብዙ መውለድ ይመረጣል ብዙ ከወለዱ ብዙ ቤተሰባዊ ትስስር ይፈጥራሉ "በየበሩ ዘመድ አብዛ" ይባላል እዚም አማች መጣላት እዚህም አማች መጣላት ይባላል አማቻዎቹ ደሞ የሚሰጡት ክብር አለ በአካባቢው ተቀባይነቱ ክብ የጎላ ነው። አነድ ከወለደች ወይ ልጅ ከሌላት ምን ይቺ ነጠላ ከለሆደ ምን ታውቃለች ነው የሚባለው ::
>
> Motherhood requires a lot of sacrifice: feeding children, going through a lot of challenges. I raised this boy [showing me the little boy who was taking a nap next

to us] because I don't want my daughter to go through the hassle. [Her daughter works in Jidah, Saudi Arabia]. I also refused to sell the land because they [her children] need a place. I am telling you, raising children isn't easy, it is a lot of work. (Emama Halima)

እናትነትማ ሲርበው አብልቶ፣ ተቸግሮ ተጠምቶ ጠቁሮ ከስቶ እናትነው አሁን ይህን በሰው የምታይው ልጅ እንዳትንገላታ ልጇን ወስጄ አሳምሬ አሳድጌ ልጇን ልጆች እንዳይቸግሩብኝ በታይቱን አልሰጥም ብዬ ይዤ ነው እንደዚህ ነው እናት እንደዚህ ብትሆኑም አሁን መከራ አይታችሁ መከራ ታይቶ ነው የምትማሩት። ዝም ብሎ አልተወለደም ልጅ ነው የምልሽ ስራ አለው::

The above quotations show the contrasting sides of motherhood and unfold some of the socioeconomic challenges that are embedded within. Traditionally women are responsible to be fertile and bear children, while men are responsible to ensure the continuity of their linage. For any reason, if couples do not have children, the women are blamed and stigmatized without any medical proof. The men are allowed to marry another women and fulfill their duty – ensure the continuation of their lineage, as men are usually perceived 'fertile'. These assumptions create psychosocial and economic pressure on both men and women since they have to deal with divorce/separation and the additional stigma [especially for women] that comes with being a divorcee. Most women endure physical, emotional and psychological abuse from their partners, family members, and the community to avoid stigma. Some women stay in the marriage knowing their husbands have affairs. Some even allow them to have an affair and bring the baby home. Hence, autonomy and ability to make informed decisions are major challenges that are related to sociocultural norms.

Motherhood is also surrounded by a different traditions and rituals that foster community support for expectant mothers and new mothers during the first 40 days after delivery, *Aras.* These rituals have social, cultural and spiritual significance for the mother, family members, and the community as a whole. During the last term of pregnancy every food ingredient that would be used after birth, will be prepared and tested. The 'testing' is a ceremony where family, friends

and women in the neighborhood gather together to eat, chat and wish the expectant mother a healthy and peaceful delivery. This ceremony - *genfo kemesa*, *Fatima kori,* has blessings and prayers. Close family and friends also gather to support the mother during birth. They provide all the advice, encouragement and prayers to build the mothers strength, and help in every way they can during birth. We may compare them with doulas in the Western countries, but they are not 'professionals' and provide more hands on service after delivery. They clean up the cloths and the room after birth. After birth, mothers can never be left alone during the first 40 days. If she is alone, it is feared that she easily be exposed to 'bad' spirit and lose her mind. Hence, mothers will be cared for by families, friends and their community. Perhaps this is why postpartum depression is rare in the community. Overall, ceremonies, rituals and traditions ensure that expectant and/or new mothers get all the necessary physical, emotional and spiritual support needed until they regain their normal strength. The rituals and traditions also highlight the significance of a mother and the role of motherhood in the community.

These narratives magnify the importance of "accompaniment" in maternal health. Dr. Paul Farmer, on his transcript *Accompaniment as Policy* defined accompaniment as "an elastic term: it means just what you'd imagine, and more. To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end." (2011, p. 1). In North Wollo, the traditional community based maternal support system embrace the value of accompaniment. Women in the community stick together and support each other during good and bad times, happiness and melancholy, weddings and funerals, birth and death. As described earlier in the section, community members provide support for women during pregnancy, by volunteering to do household works that might be a threat to her health – fetching water, carrying heavy materials, going to flourmills, and working in the field. During

birth, they all come together to provide emotional and spiritual support. After birth, they clean up the delivery room (in case of home delivery) and the baby. While *Aras* (the 40 days after birth) they feed the mother, manage the household and care for the baby. The community accompany mothers throughout the process of birth, until the mother recover from the trauma of birth, regain her strength and get used to new situation in her life journey: being a mother. In the traditional support systems, the community accompany the mother from the start – pregnancy, to the very end- until she regains back her strength after birth.

Accompaniment is a major part of structural social work principle since it solidifies the mutual service provider – service user relationship. Structural social work is critically reflective of systems of oppression. Service providers that adhere to structural social work practice base their relationship with service users on mutual dialogue rather than top-down interactions, since structural social work is founded on the values of humanitarianism and egalitarianism, which are the bases of social democracy that adhere to the socialist paradigm (Mullaly, 2007). However, the health system is constructed based on neoliberal policies that are developed by Western countries to be adopted by the rest of the 'third world' or 'developing' countries. This top-down approach to policy and program development as well as implementation is observed throughout the system, including service provider – service user relations. If we examine the health sector development plan in Ethiopia that is a reflection of MDGs, it is easy to grasp that mothers are viewed as individual patients who need access to facility based reproductive health services, prenatal, natal and postnatal care to enhance their health. And currently after endorsing SDGs, the National Planning Committee is working closely with the UNDP to mainstream SDGs and align the national goal fully with SDGs (UNDP report, April 26, 2016). This individualistic perspective ignores the collectivism in the community, and the sacredness and the performativity

of motherhood. It also alienates mothers from the rituals, ceremonies and traditions that define their essence of being a mother. Hence, stakeholders in policy formation and implementation need to reflect on approaches that would help capture the panoramic view that surrounds motherhood and maternal health, using the scarce resources available in the most effective ways.

Contemporary literature (e.g., Denzin & Lincoln, 2008; Gray & Coats, 2010; Morgensen, 2012; Nicholls, 2009; Tuhiwai-Smith, 2012) informs us that using Indigenous approaches can help to capture and understand important nuances within a given context, while allowing the voices of the community members to be heard. In this specific case, understanding how women in the community define mothers and perceive Motherhood expanded my perspective on motherhood. I also believe that the collective voice of my research participants could influence those who may read this study. Listening to these voices will give community members a chance to speak out and actively engage in various platforms to support their wellbeing. In addition, it allows various stakeholders to know and address the real needs based on their priority, ensuring sustainable change.

Deliberating on maternal health needs, research participants identified access to basic needs such as nutritious food, clean water and shelter, basic infrastructure such as road, and electricity, economic/financial support, and education. Health extension workers who were part of the research also identified access to reproductive health, pre-, post- and natal care as needs of mothers in the community.

2. Access to Basic Needs and Economic Empowerment

Poverty is the central challenge for the community in North Wollo. For mothers, poverty combined with their lack of access to monetary income and basic literacy contributes to their

complete dependency on their husband and lack of autonomy and decision making power in their household, including issues related to their reproductive health. As indicated by some research participants many women do not use contraceptives; if they use contraceptives most of them do it without the knowledge of their husbands. This situation often limits their contraceptive choices to Depo-Provera, an injection which works for three months. If mothers take depo shots, they do not have to worry about it for three months, and they can get the next shot when they go to the market, which explains why health posts have relatively high number of 'patients' during market days. Coming back to economic needs of mothers, research participants identified that the stresses of providing children with their basic needs and managing the household adversely impacts mothers' health. Moreover, since she has to prioritize her children and her husband before herself (which is part of the sacrifice imbedded in motherhood), she will be starved, face nutritious deficiency and become vulnerable to various infections. Serke remind us that "health is parallel to one's socioeconomic status. It is very difficult to stay healthy in this community due to economic deprivation. People die so young because they are poor." Hence, addressing poverty and providing economic support that enables mothers/woman to contribute to her household and/or be self-sufficient is the primary need of mothers in North Wollo to enhance maternal health.

This finding is in line with the findings of Woldemicael & Tenkorang (2010) who used the 2005 Ethiopia Demographic and Health Survey (EDHS) data, incorporating the responses of 5,560 currently married women who had their last live birth in the 5 years preceding. They analyzed women's health-seeking behavior in Ethiopia in light of physical, demographic, socio-economic, and health related variables. Their findings revealed that women's freedom of mobility, control over household resources, ability to make decisions on household purchases,

freedom from domestic violence, participation in child-related decisions determine their health service utilization.

The World Health Organization (1995) recognized poverty as a destructive influence of human life from conception to death. Poverty is a complex structural burden that weighs on individuals, communities, and countries. The poor suffer from economic, psychosocial, emotional pain throughout their life due to discrimination and lack of access to basic needs and basic infrastructure, which is highlighted in the next subsection. As Farmer (2005) argued the poor are more likely to suffer, but their suffering will not be noticed since existing structures shadow their suffering and the injustice, forcing them to contain their pain and die in silence.

My reflective note dated 12/12/2014 may shade some light on how the suffering of the poor is shadowed and hidden from the general public. I spent that day in *Tesfa Giorgis,* a cold windy village on the hill, and one of the inaccessible *kebeles* in North Wollo. After I finished my observation and interviews, we drove back to Woldia, listening to the national radio. A government official was making remarks on how the rural community is benefiting from the agricultural extension program that provide farmers access to fertilizers and irrigation based farming, in addition to the usual seasonal farming. Then, he commented on how some people are not driven enough to get out of their situation and fully utilize this government programs. The last comment was so painful and emotional for me. After staying in *Tesfa Giorgis* that day, I have witnessed how difficult rural life could be if the whole village is poor. There is no access to transportation. The walk to the nearest town ranges from 3 – 5 or more hours depending on where you live. The extent of poverty in the village is despicable. One can see the cold wind batter children's faces and hands since they cannot afford to have the proper gear to protect themselves. But no matter what, the children are playful and happy, the adults hard working and

determined. For me every member of this community members are warriors who struggle to meet their needs. They fight with natural catastrophes: challenging weather conditions, famine and drought; they also fight their socioeconomic challenges that puts them, their children and their forefathers under economic oppression and discrimination. But they are addressed as “not driven to change” on public media by a general remark of a government official that merges every ‘poor’ rural farmer together. I thought maternal mortality is explained by government in the same manner: “maternal mortality is high because mothers in the community don’t want to use the health facilities”, which is far from the truth.

Figure 29. The arid land of Tesfa Giorgis

At the time international agendas are set to discuss about quality in health care, the poor do not even have access to care. Their challenge is beyond comprehension because, as Farmer would say it, their suffering is hidden from public eyes to avoid discomfort for the powerful. Therefore, it is important to use structural social work and social justice frameworks to fully comprehend the influence of poverty and maternal health needs in North Wollo.

3. Access to Basic Infrastructure

The other salient need identified by research participants was access to clean water and energy supplies. In addition to the health benefits, easy access to clean water minimizes the work burden on mothers and girls who are responsible to fetch water from the nearest water source which may be up to 3 hours away by foot, carrying up to 20 liters of water in large containers on their back. (Donkeys are also sometimes used to carry water.)

Figure 30: girls and women fetching water from the nearby river

As one research participant highlighted, the work burden on a woman who fetches water from the river is very different from the one who gets water from her backyard. Similarly, a woman who cooks and bakes using electricity or solar energy streamed in her house reduces demands on time and energy for collecting firewood and making charcoal. Having easy access to important amenities such as electricity and other energy supplies (kerosene, solar energy, or methane) improves women's wellbeing. It also minimizes the risks of back injury that could happen due to carrying heavy loads, as well as sexual assault and rape that mostly happen while women and girls go out to fetch water or collect firewood.

4. Access to Education

Providing women access to education has been in the forefront of safemotherhood programs since Mahler (1987). Research participants also argued that mothers/ women need to be educated in order to make informed decisions of any kind. Historically parent's do not send their girls to school for multiple reasons, including lack of access to schools, and fear of harm to their girls including rape and abduction. Also, in the past education was not deemed necessary for girls. Elementary education has been universal only in the past 10 years. Hence, changing the disparity between male and female in the school system may require generations and commitment. However, the focus of research participants was awareness-raising and skill-building, not formal schooling because they indicated that schooling does not guarantee employment. Research participants told me that their children are still living with them after investing 10 years of schooling (completing high school) because they could not find a job and they cannot proceed to the higher level of education because they did not pass the national entrance exam. In Ethiopia, even if the passing points vary, one has to pass the national examination to join any higher academic institution, including technical and vocational training. Some went to Saudi Arabia to work as housemaids since they thought they would be able to support themselves as well as their family. However, my research participants who had been in the middle east told me that it was so difficult and they felt like a 'prisoner' there because they work in a very restricted situation in a foreign country, had difficulty with the language, and were dependent on their 'masters'. For a period of 2-5 years they were able to work and help their family, but they had to comeback 'home' to get their 'freedom'. But, Tayech said, "there is no freedom in poverty. I don't want to be dependent on my parents again. But I couldn't find a job here. It's farming. There is nothing here." Tayech went to Saudi after she finished grade 6.

She did not pursue her schooling; hence she cannot find job. However, just like other research participants, she strongly believes that skill building, or vocational training coupled with financial support (seed money) would help her find a way to sustain herself and her family.

Access to pre and postnatal care, as well as professionally assisted delivery were identified as needs of mothers. In general, the needs research participants identified are very much interconnected. Hence, meeting the needs of mothers requires addressing structural problems, including poverty, within the community. It is possible to argue that poverty is the cause of many problems, however it can also be the consequence – it is a vicious circle. It is also important to think and speak in social justice terms to address such complicated and interconnected needs. Article 25 of the Universal Declaration of Human Rights (1948), which is ratified by Ethiopia along with most other countries in the world, states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance." Hence, human beings have the right to fulfill their basic needs, they have the right to access food, clean water, and shelter. Both men and women have a right to live a healthy and dignified life make autonomous decisions that concerns their wellbeing.

5. To What Extent Have Mothers' Needs Been Meet?

As a country, the government of Ethiopia was committed to achieve MDG 5 to improve maternal health and reduce maternal mortality ratio by 75% from 1990 to 2015, through improving access and strengthening facility-based maternal services. The current international policy framework under SDGs also focus on reducing maternal mortality through universal

health coverage (Article 26 of the SDG Declaration). The Ministry of Health strongly believes that maternal mortality could be reduced if women have easy access to family planning, antenatal and postnatal services, as well as skilled attendance of deliveries. However, the demographic health survey (EDHS, 2011) revealed that only 10 percent of births in Ethiopia take place at a health facility. EDHS also indicates that about 15 percent of pregnancies lead to life-threatening complications. Examining this government statistic and the substantial difference revealed by research participants between the needs and demands of the community through visual dialogue, it is possible to say that most of their needs have not been met.

Figure 31 visual representations of maternal health needs vs. supply – the smaller items representing supply

Reserch participants identified community based traditonal services as well as policy-led facility-based services that enhance maternal health in their community. Community based traditional services provide more rounded support for my mothers as well as their children starting from pregnancy to delivery and the 40 days after delivery (*Aras)*. This services include minimizing the work burden of expectant mothers during pregnancy through fetching water, collecting firewood, and preparing food; providing emotional and spiritual support during delivery; accompaning new mothers, caring for the new born child, preparing food, cleaning and managing the household after delivery. These services are voluntary and grounded in traditional as well as spiritual values of the community.

However, poverty and HIV/AIDS are disrupting these voluntary provisions. Most communtiy members cannot afford to share their limited resources with their neighbors. Many people do not know their current HIV status. Even if they know, it is very confidential due to the stigma and discrimination attached to HIV/AIDS. Therefore, community members, including traditional birth attendants are resistant to fully help mothers during birth, especially in the absence of any protection (gloves and plastic bags). Moreover, traditional birth attendants may not be able to identify complications before delivery since they do not provide prenatal services unless the woman is in pain and needs their consultation. Therefore, to avoid the risk of contracting HIV/AIDS through blood contact during home birthing and identify delivery related complications on time, the government is promoting facility based delivery. Community members are utilizing these services at higher rates than the prior years.

The other major challenge in community based traditional services is ensuring the continuity of homebased delivery since most traditional birth attendants are deceased and those who alive are aging. They cannot even impart their skills to the coming generation since homebirth is viewed as 'outdated' and even legally sanctioned in various places. Traditional birth attendants are also encouraged to change their 'profession' and join the government to promote facility based delivery, as Sindu confirmed: "I was a traditional birth attendant for more than a decade. But now I am a member of homebirth eradication committee...". The formal religious institutions (Christianity and Islam) are also separating themselves from the traditional ceremonies and rituals, associating rituals with 'bad spirit' and a work of 'devil'. Young mothers I interviewed, just like their peers in the community are in dilemma. They are relatively more educated, and identify themselves as 'modern' Christians or Muslims. They still participate in rituals and ceremonies for their 'social values' than 'religious values'. However, accessing and

utilizing health facilities is challenging for the youth in the community. Given this context, the major question to ask might be: is it a wise strategic move to get rid of traditional rituals and ceremonies [by demonizing them] to enhance utilization of facility based delivery? Is it even possible to get rid of traditions that withstood generations of cultural erosion?

Policy-led facility-based services include family planning services, pre and postnatal services and skilled attendance of deliveries. Except for delivery services, all the others are delivered by health extension workers. Research participants mentioned that they are more comfortable with health extension workers since they are all women who could better understand their biological and sociocultural challenges. Delivery services are provided in health centers and/or hospitals. Health centers facilitate normal deliveries. If there are any birth related complications, they refer patients to Woldia Hospital. Theoretically, there is a designated ambulance that transports mothers in labor from their home to health center and from health center to hospitals. However, the reality is full of glitches: at times it's hard to get hold of the driver because of the poor telephone network, or the ambulance cannot be used due to the shortage of gas supply in the area, or there is no road in the village. Moreover, health posts cannot give proper services to the community because there is a shortage of gloves, or there is no electricity, or no medication. The freezer or the refrigerator they have is used as a shelf to keep medication. Some health posts are full of dust since they are made of wood and mud, without a cemented floor. They can even hide rats, lizards, and snakes.

Analyzing the gaps in facility-based services that were identified by research participants, it becomes apparent how detached facility-based services are from the cultural norms and practices of the community. Having male midwives in health facilities to assist delivery, while every tradition and rituals within the community centers on women as prayer leaders during

pregnancy, birth attendants during birth, and care givers after birth during the first 40 days is one example of this basic disconnect. Another is not allowing family members in the delivery room, a situation the leaves a mother with a male stranger or even alone while he [the midwife] helps other mothers, while the traditional norm dictates mothers should never be alone during birth, or even after birth until they recover from the trauma of birth and gain back their strength. Having male midwives is a reflection of the country wide problem related to girls' and women's access to formal education system. Free and universal access to primary school education is a recent phenomenon in the country. Hence, building the professional base will definitely take some time as will increase professional training. However, if we must wait for girls and women who are in school now to start have female midwives, it will take a generation to change this situation in rural Ethiopia.

This situation also highlights gaps in terms of service delivery quality as well as service utilization. For research participants, quality health services include welcoming environments in the health facilities, starting from the structure of the building, the layout of the rooms and furniture, and availability of enough beds to accommodate patients and clean latrines. They also emphasize the importance of having courteous and competent staff who can treat the community with compassion and professional ethics, and who are held accountable for their actions rather than nurses who slap mothers in labor for shouting, or doctors and health officers who order unnecessary lab tests from their own or their colleagues clinics for their personal monetary gain.

Figure 32. conceptual framework for quality service delivery

Therefore, it is possible to conclude that the approach of the government used to enhance maternal health and reduce maternal mortality does not address the holistic needs identified by research participants. When participants discuss maternal health needs and maternal health services they did so holistically. Unlike the policy-led facility based services, research participants' explanation did not focus exclusively on medical needs during pregnancy, birth, and after birth. Their major focus was the emotional and socioeconomic needs and supports. They discussed easing the work burden of mothers in the house and accompanying them through the process of birth and postpartum assisting in basics day to day activities such as cooking, cleaning, collecting firewood, fetching water and managing the household. Traditional community based services and the spiritual values placed on motherhood and helping new mothers allowed mothers to recuperate their physical and emotional strength, after going through the traumatic experience of giving birth.

In addition, there is an enormous gap in service provision as well as service utilization due to lack of basic infrastructure, awareness among both women and men and women's autonomy, as well as culturally incompetent services. Therefore, to enhance service utilization, the government need to develop basic infrastructure, strengthen awareness raising programs that include men as major actors as well as supporters of maternal health, emplace culturally competent and quality services, updated equipment, clean and attractive structure, as well as compassionate and qualified staff. Therefore, as a Zone, North Wollo has a long way to go to meet the needs of mothers using community-based as well as facility-based services that enhance maternal health and reduce maternal mortality.

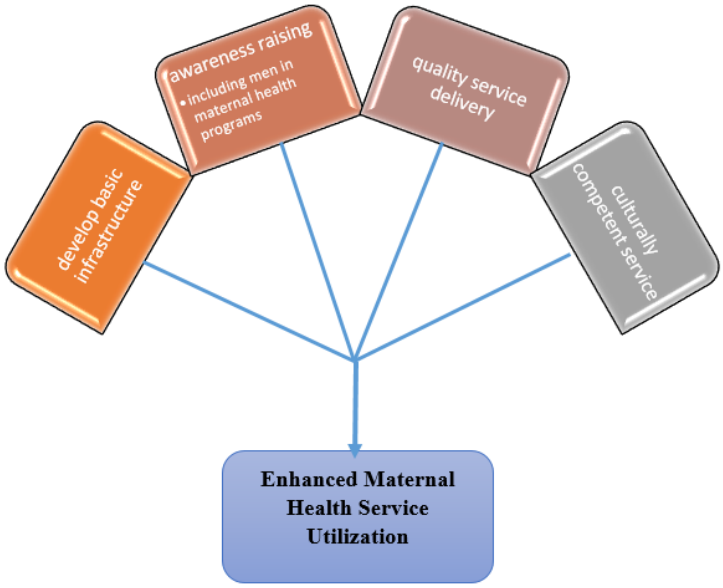

Figure 33: variables that may enhance maternal health service utilization

6. What Has Helped the Most?

Research participants acknowledged the importance of having access to free family planning, pre and postnatal services, and skilled delivery attendance. They also acknowledged the importance of quality prenatal care and skilled delivery to reduce maternal mortality in their

community. However, almost all agreed that traditional community based services help mothers to cope up with their challenges better. As indicated in the previous section community-based support systems provide rounded support to mothers that would help them cope with their challenges, thereby enhancing their health and wellbeing. Community has well established structures/ associations such as: *idir/kere, senbete/mahiber* and other support groups that provide physical, psychosocial and financial support for members. These structures also provide emergency response for community members. Bethel indicated that "for a woman in rural village, her community is her primary support. … her neighbors are the ones who get her to any medical facility since she has to be carried in a stretcher bed." Birthing, just like death, is perceived as a natural phenomenon. Hence, community members do not want to associate birthing with some kind of disease that requires medical attention. Therefore, most mothers avoid going to health facilities for delivery or checkup unless it is a must. Mothers do not see health facilities as life-saving since they have witnessed so many deaths in health facilities. maternal mortality in the health facilities can be the result of incompetent health service quality: lack of emergency obstetric care, lack of skilled professional, electric power disruptions during a procedure, lack of enough medication and equipment. Hence, for the community God/ Allah is the *only* life saver.

For new mothers, the first 40 days after birth (*Aras)* is very crucial. Mothers need care and support to regain their strength, and to heal from the physical as well as psychological trauma of birth. Hence, community members (women) make sure that the new mother is accompanied and cared for during this time, whether she has family or not; whether she gave birth at home or at health facility. Ethiopian labor law allows employed mothers to have 3 months of paid leave during their last months of pregnancy and after birth, which helps mothers

to gain back their strength and helps newborns to grow healthy under the care of their mothers. Even if the legal structure allows women to stay home during this time, it does not provide additional support. Hence, community members provide the day to day care and support the mothers require during this time. Emama Halima mentioned: “It is the community that support each other! Government don’t have enough resource to support everyone…. Government tell you to have prenatal checkup …. But the real hands on support is from the community [cooking, cleaning, feeding, accompanying…etc.]”.

Overall, Maternal health includes the overall wellbeing of mothers, which requires addressing structural problems such as poverty, women’s education, economic independence and decision making power or autonomy in her household. Research participants clearly separated education and schooling. They used education to mean awareness raising and technical skills that can be used to make informed decision and generate income, while schooling was the formal route their children has to go through that requires attending schools and passing examinations. Hence, in addressing women’s education, awareness raising sessions and building technical skills was the focus. Literacy- being able to read and write is also a major need that needs to be addressed. Enhancing maternal health also requires access to basic day to day provisions such as clean water, flourmill, electricity and/or other energy supplies; in addition to family planning, pre- and post-natal services, and skilled delivery attendance.

a. Major Actors Involved in Maternal Health

The major actors involved in the complicated dynamics of maternal health include:

- Pregnant women in the communities;
- Traditional birth attendants – experienced women who assist mothers during homebirth;

- Health extension workers – provide family planning services, identify pregnant women in the community, calculate the estimated delivery date (EDD) and provide prenatal care, refer women to health centers for delivery;
- Health professionals (midwives, nurses, health officers and doctors, if any) – provide professionally assisted facility based delivery in health centers and hospital; and
- Families, neighbors and the community – provide community based care for new mothers and their children during the 40 days after birth.

All actors function within a given structure that frames their relationships, i.e. the national health policy, existing infrastructure, and culture and traditions within the community. As illustrated in the following figures, even if they are designed to serve pregnant women in the community, existing community based support structures are different from policy-led facility-based maternal health services. The community based support structures are influenced by culture and traditions, while facility based services are driven by national policies. Moreover, community based support consider traditional birth attendants and community members as major players, while facility based services focus on health professionals and health facilities. The national health policy urges expectant mothers to have professionally assisted facility based birth. And in order to promote facility birth, traditional birth attendants are prohibited from assisting homebased delivery by the local government. In some places traditional birth attendants as well as mothers who give birth at home are fined. After rolling out traditional birth attendants the national health policy introduced health extension workers as community based prevention-based health service providers, (described in detail on chapter 2, p. 37) and agents for promoting pre and postnatal care as well as facility based birth. However, examining the infrastructural challenges such as: lack of roads, transportation, electricity and telecommunication, it is

impossible for expectant mothers to access and utilize facility based services. Moreover, the national health policy did not accommodate cultural and traditional norms that surrounds birthing in its service delivery. This disconnect is manifested having men health professionals that assist delivery.

Community support is common for both community based support systems as well as facility based services. Whether a woman gave birth in a health facility or at home, families and community members render their support during the 40 days after birth (*Aras*). The persistance of community support indicates the significance of culture and traditions to community members, and the continious support and 'acompaniment' mothers need to cope up with the physical, psycological and emotional trauma of birth, including post partum depression.

Figure 34: Actors and structures: community based maternal health support system vs. policy-led facility based maternal health services

b. Major Constructs that Explain Maternal Health in North Wollo

Based on the findings, the major constructs that explain maternal health include: the notion of motherhood, traditions, norms and rituals, maternal health needs, international maternal health policies and programs, maternal health service (community based services and policy-led facility based services), service utilization, and enhancing maternal health/ reducing maternal mortality. These constructs are interconnected. It is difficult to address issues related to maternal health without considering each construct. As summarized in the following conceptual framework, beliefs, traditions and rituals influence how we define motherhood and maternal health needs, our service seeking behavior as well as service utilization. Beliefs and traditions also provide the foundations of community based traditional maternal health services. Therefore, they are salient constructs. Maternal health needs also influence service provision and service utilization. Given the need for specific services, service utilization will clearly be necessary. However, in maternal health, which embodies the natural phenomenon of birth and death that is full of traditions and rituals, service provision needs to be culturally relevant. If international policies and programs do not consider the cultural foundations of a given community, then it will be difficult to address maternal health needs and enhance service utilization. The following conceptual framework figuratively illustrates the links and disconnections between these factors that influence maternal health service provision and utilization. The broken line indicates the weak link between factors, while the bold line indicates strong relationship or influence between factors. Arrows demonstrate the direction of influence.

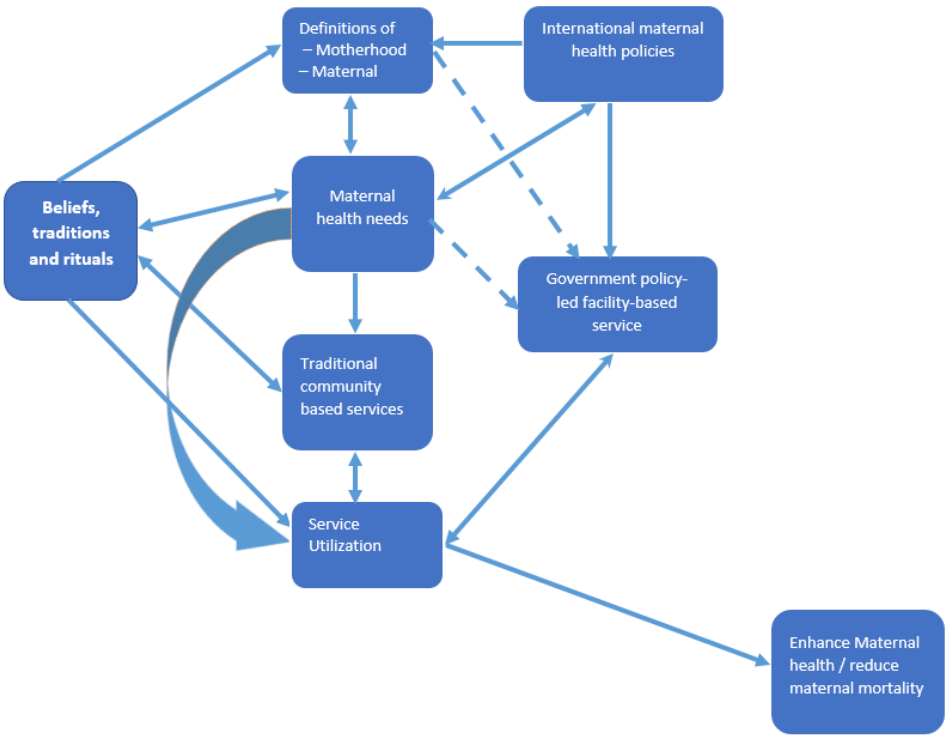

Figure 35: factors influencing maternal health service provision and utilization

7. Recommendations to Enhance Maternal Health

In North Wollo the unspeakable impact of poverty is observed in every sector of development – health, education, or agriculture. Therefore, enhancing maternal health requires addressing poverty, which is very complicated and largely beyond the scope of this research. Nonetheless, research participants suggested that providing economic support for mothers in the community, by engaging them in income generating activities, building their technical skills and financial literacy augment women's financial contribution to their household and their autonomy, thereby improving their wellbeing and health. These steps would be a start on addressing some of the daily impacts of poverty.

The new health system in Ethiopia (2003) introduced health extension workers as community level health service providers. In the past two decades, health extension workers brought significant changes in terms of reducing preventable diseases through sanitation, malaria

prevention, and vaccination. They also enhanced contraceptive coverage. However, the Ethiopian demographic and health survey shows that they could not substantially enhance prenatal and post-natal care coverage, or well as facility based delivery [19%, 6.7% and 10% respectively]. Therefore, research participants recommended training and building the 'scientific' knowledge of traditional birth attendants (TBAs). TBAs have enough knowledge about birthing and the experience and maturity to handle stress. Therefore, training them would help the community better than replacing them with new 'professionals' or 'para professionals'. If TBAs and new graduates work together they could each benefit from the another. TBAs can share their wisdom and experiential knowledge while the new graduates bring more 'scientific' knowledge. TBAs can also bridge the gap between the community and the formal health institutions since they are from the community, they have personal relationship with mothers, and not considered as strangers.

It is not arguable that homebirth, especially with the risk of HIV/AIDS and the unpredictability of pregnancy related complication, is risky to mothers in the Ethiopian village context. Recognizing this risk, the government is also pushing for facility based birth. However, facility based services are yet adequate in terms of coverage or quality of care. Starting with shortages of professionals and basic supplies such as gloves, cleaning materials, and medical supplies such as pain killers; along with the issues raised by the male majority among midwives, health facilities face serious challenges and limitations. Given this context, it is also difficult to build trust within the community so that mothers accept health facilities as honest and compassionate partners since they have heard and observed horrific incidences including death in health facilities, especially hospitals. Culturally, death is perceived to be unescapable condition,

and if it is to come, village people prefer to face it at home in the company of loved ones than in a hospital surrounded by anonymous professionals who are just doing their job.

To enhance facility based birth, it is important to create a welcoming environment in health facilities and provide culturally competent services. The interviews confirm that culture influences health service seeking behavior and utilization of services. Hence, provision of quality service requires rebuilding the culture in health facilities in ways that are responsive to and emerge from indigenous practices, values, and cultural contexts. Having birthing centers instead of a ward in a hospital/ or a health center may attract more mothers to health facilities. In communities where birthing is considered a natural phenomenon, it is important to detach delivery from over medicalized environments and procedures. It is also important to allow at least one known person in the delivery room. Health facilities can also allow families to carry out simple ceremonies such as coffee, and *genfo [Mariam Meshegna]* after delivery. Health extension workers confirmed that a couple of health centers allow these ceremonies and that as a result more mothers have come to use their facilities for delivery. It is also mandatory to provide health professionals and staff members with continuous ethics and customer handling training, as well as increased exposure to traditional practices. During my observation, I have witnessed that many nurses and receptionists can be snappy and rude. Even if there is overflow of patients, this needs to be corrected. No one wants to be disrespected and yelled at, especially mothers in labor. I share the opinion that no women should die while giving life as a result of inadequate support, care, or facilities. And I strongly believe that it is possible to minimize maternal mortality, if everyone, including local communities, have opportunities to contribute to enhancing maternal wellbeing.

This project, as exciting as it is for me, has also been challenging and complicated. It is very difficult to come up with a specific solution or intervention to curb maternal mortality. Maternal health requires rounded and culturally relevant interventions that focus on economic, social, physical, mental, emotional and spiritual wellbeing of mothers. In North Wollo, it is important to address basic structural needs including access to basic education, clean water, access to energy sources, and women's economic independence, in addition to pre- and post-natal care and support. The findings from the interviews as well as visual dialogues elaborated the salient sociocultural position of mothers in the community as well as the melancholy that is felt when maternal mortality occurs.

B. The Process of Decolonization and Indigenous Knowledge that Emerged

Various scholars stressed the importance of decolonizing research (Gray & Coats, 2010; McCleland, 2011; Thiong'o, 1994; Tuhiwai-Smith, 2012). Decolonizing is not a onetime event, but a process of decentering power structures (Gray & Coats, 2010). In research decolonizing requires ethically and culturally acceptable approaches to the study of issues involving indigenous people (McCleland, 2011; Tuhiwai-Smith, 2012). In this research, the decolonizing process started first, by acknowledging women who are often 'targets' of policies, as 'experts'; and provided a space for their voices to be heard. These primary step ensured the self-determination of women at the grassroots. Second, by using indigenous approaches and methodologies to frame the questions, to collect as well as analyze information/data.

At the beginning, I recruited a research assistant (Melkam) who is born and raised in North *Wollo,* and returned back to work in this community after being away for several years for school. We recruited gatekeepers together. And potential research participants were identified with the help of gatekeepers – elders, community leaders and service providers. The diversity in

gatekeepers' background helps to ensure the diversity among research participants, since different gatekeepers have different aquintance and different circle of influence. Gatekeepers are important assets in indigenous research since they help the researcher to gain access and develop trust with the community of study (Hatch, 2002). They also enhance the process of relationship building between the researcher and potential research participants which is a cruital for the success of indigenous research (Kovach, 2010; Sheehan, 2011; Tuhawi-Smith, 2011). Then, I arragned informal sessions with these participants to ensure voluntary participation and build rapport. Once, the rapport is built and they agree to be part of the research, research participants decided the time and place of the interview. All interviews took place in a natural setting – participants' home, at the back- or front-yard, where participants are more comfortable in. The familiarity of the space created more ease and more trust. Moreover, my willingness to travel proved my eagerness to learn than to excerice my expert power as a researcher. Also, interviews were carried out using the native language –*Amharic*. In general, data was collected using in depth interviews, visual dialogue and observation which is part of the day to day process of knowing and knowledge development in the community. I first coded the data with Melkam so that I can identify themes and capture all the important nuances in the data. Using someone from the community in the data analysis process gave the data more life, and strengthened the indigenous voice.

Gray & Coats (2010) argued that decolonization involves a commitment to an authentic approach that requires becoming genuine, or going back to one's roots to seek direction, moving away from adopting Western theories and practice approaches. Hence, I started learning about maternal health in *North Wollo* from the stories and experiances narrated by women who have the firsthand experience of maternal health programs as mothers or potential mothers. Their

stories and experiances about motherhood, the traditions and rituals that accompany pregnancy, birth and the afterbirth were genuine and profound. While telling these stories, they were so pround of their traditions and community based support systems that has existed for generations, and still are the main support systems for mothers.

The use of in-depth interviews minimized the researcher- participant power dynamics and allowed more flexibility for research participants to address and shape the research questions. Assessing participants refelction and narratives, 'motherhood' and the rituals surrounding the birthing process (which were not part of the overall research questions) emerged as importat concepts to fully understand maternal health needs and services in the community of North *Wollo*.

Mattaini & Holtschneider (2016) defined the core mission of social work as "taking action to realize a progressive vision of a just and caring society". They also highlighted three major requirements to fulfill this mission: (1) challenges oppression and structural violence wherever found, (2) offers care and accompaniment for casualties of systematic oppression, and (3) co-constructs an ecological field advancing individual and collective health and liberation. (p. 1). As a social worker studying maternal health in Ethiopia, I challenged oppression and structural violence, and co-constructed an ecological field advancing individual and collective health through employing indigenous methodologies, allowing women at the grassroots voice their needs and recommendations for improving their health, challenging the expert led top-down approach to policy formulation and implementation. I will also continue to offer care and accompaniment for women in *North-Wollo Zone,* Ethiopia, by designing and implementing community based maternal health projects in the near future.

Overall, this research decolonized the research approach, and captured deep reflections on the cultural accounts of motherhood, maternal health needs and services, as well as insightful recommendations on how to enhance maternal health in the community using bottom-up interventions and strategies.

C. Limitations of the Study

This research is a qualitative study that uses observation and in-depth interview techniques for data collection informed and shaped by Indigenous research methodologies and structural social work theory. Indigenous methodologies are culture- and context-specific. Moreover, as Silliote & Marzano (2008) pointed out, developing Indigenous knowledge development requires substantial time, effort and resources. As this is a dissertation the resources available were limited, particularly in terms of the amount of time that could be spent in the field, which was about 12 weeks.

In addition, this study is focused on North Wollo, which is purposefully selected because of my prior relationship and familiarity of the place. Even if my familiarity with the place is beneficial to understand the cultural nuances and contribute to the credibility of the analysis presented, it limits the study of maternal health to the sample of women in North Wollo. The transferability of these findings to other contexts and/or participants is also dependent on consistency of selected sample, and sociocultural and economic context of selected places.

I have used variation sampling, a second coder, thick description, memoing, frequent consultation with the chair of my dissertation; and conducted a member check to reduce potential researcher bias and ensure trustworthiness of findings (detailed in the methodology chapter). To ensure variation, research participants are recruited purposefully. To facilitate the recruitment process, several gatekeepers with different socioeconomic backgrounds and circles of influence

were used. Research participants also have different socioeconomic and demographic backgrounds. I used my research assistant as a second coder to better understand and capture all the important nuances in the data. Using someone from the community in the data analysis process strengthened the Indigenous voice. After the preliminary analysis, I conducted member checks with eight participants to verify my analysis, decrease the chances of misrepresentation, and increase local validity. I used Circles in member checks in order to create a space where participants share their knowledge and experience without restraint (Sheehan, 2011). The member checks ensured participants' contribution and ownership of the co-constructed meanings of motherhood, and maternal health in North Wollo. The feedback from participants also added more richness to the findings and shaped the presentation of my finding chapters. In addition to transcribing the data, I heard the interview records and read the transcripts and memos several times to ensure that I understood and captured the right themes, patterns and meanings. I also had frequent consultation with my chair in throughout the process of shaping this research – from design, data collection, analysis and presentation.

D. Potential Implications of the Study

This study has important implications for social policy, social work research and practice as well as social work education.

1. Implications for Social Policy

For countries like Ethiopia, it is important to reflect on the trends of policies, national strategies and development programs that have been carried out under the United Nations framework: Millennium Development Goals (MDGs) from 2000 – 2015 and now Sustainable Development Goals (SDGs) from 2016 – 2030. These global goals are very important since they set the directions of development policies, especially in the developing world, and allocate

important funding to implement those policies. International policies also set standards for implementation of programs, monitoring and evaluations.

This study analyzed gaps in policy and implementation of maternal health programs in Ethiopia by learning from rural mothers, who are primary targets of policy and programs. The results of the study reveal gaps in maternal health program planning, service provision, and service utilization. The study can also be used to start conversations on reconciling maternal health needs in the community with international programs and interventions that are tailor made to fit all. This is a major challenge especially for countries like Ethiopia. As a target country (for almost all international programs), it is important to ratify and accept international programs that come with possibilities of large grants. For a country that has been fighting poverty every dollar counts and may save lives.

Examining the socioeconomic and political dimensions in the development, ratification and adaptation of international health and development policies, the power imbalance between the 'developed' Western and Northern nations that provide loans and grants, and the 'impoverished' Southern nations that need loans and grants to carryout health and development programs. Their financial power bestowed Western nations the power to develop and enforce policies as a requirement to access loans and grants. In this structural reality, countries ratifying and/or adopting these policies, especially grassroots, have minimal or no say on the development of policies that directly or indirectly influence their day to day livelihood. Understanding this context is the bases for understanding systemic oppressions, and why barriers exist in implementation of policies and programs.

For policy makers who invest so much money on these programs, it is important to deliberate on how best to address issues like maternal health which require contextual and

culturally competent intervention. It is important to consider social justice and structural approaches, acknowledging self-determination of countries and community members, allowing target communities to design, implement, and evaluate programs that enhance their wellbeing. This is the only way to ensure sustainably and long-term self-sufficiency.

The World Bank modeled estimate (2015) show maternal mortality rate in Ethiopia to be 352 per 100000 live births, which is substantially more than the targeted 75% decrease: 275, by 2015. This data is a clear indication that we failed to reach the global target of reducing maternal mortality. This study indicates that it is impossible to reduce maternal mortality through the provision and strengthening of facility based services, which is the conventional intervention approved by the United Nations and ratified by each member states, including Ethiopia. Results of this study suggest that we need to promote bottom-up approaches for policy as well as intervention program design. As Mullaly (2007, p. 258) argued, we need to "shift the focus from distribution to procedural issues of participation in deliberation and decision making process." It is important to engage community members fully in any decision that would impact their health and their livelihood. Tedros Adhanom Ghebreyesus, the Minister of Foreigner Affairs, who also served as Minister of Health for Ethiopia, argues that "country ownership is the surest way for developing counties to chart their own courses of development and overcome the challenges they face in building effective and productive state" (P. 1127). It is vital to challenge tailor made, neoliberal and neocolonial policies such as MDGs (Saith, 2006; Sumner & Tiwari, 2009) to exercise true self-determination and live in a just world. "*The Master's tools will never dismantle the master's house (Lorde, A. 1979).*

2. Implications for Social Work Research and Practice

Culture defines people's daily life and patterns of interaction. Ethiopia is a culturally diverse country, with more than 80 languages and 200 dialects. Religion and spirituality also play significant roles in individual and communal life. Therefore, developing effective programs requires understanding the cultural nuances and engaging the community in a meaningful way starting from program planning.

This study introduced a contextual approach to study maternal health in Ethiopia, using Indigenous methodology. It is also important to social work research and practice as it promotes bottom-up approaches in program design and implementation, challenging Western theories and practice approaches. This research also allowed us to learn from the people about their context, their actual needs, and their proposed mechanisms to meet their needs, possibly avoiding the replication of futile programs. Moreover, the world needs more community based participatory research to understand community based needs and effectiveness of interventions, allowing reciprocity of the knowledge flow from the South to the West (and North) as well, in addition to the usual flow of knowledge and information from the West to the South.

In postcolonial Africa, the struggle for ethnic, sociocultural, and political autonomy is real. Even if one can argue that Ethiopia was not colonized, the nation is highly influenced by Western neoliberal policies manifested though its economic, and social policies. Therefore, decolonizing the formulation of socioeconomic policies, research processes and intervention programs is important (Chilisa and Ntseane, 2010; Escarcega, 2010; Matsinhe ,2007; Nicolls, 2007). Decolonization is a process of decentering colonial discourse and power structures (Gray & Coats, 2010), which requires ethically and culturally acceptable approaches to the study of

issues involving grassroots and criticizing the underlying assumptions, motivation and values that are enacted with imperialism and colonialism (McCleland, 2011; Tuhiwai Smith, 2012).

For social work professionals working to promote maternal health, the study highlights the importance of social justice and structural approaches. Social justice is one of the core principles in social work. The purpose of social work is "to improve the quality of transactions among clients and their physical and social environments, in ways that are consistent with social justice" (Mattaini, 2008, p.355). Social justice requires efforts to confront/overcome any norm, social condition, social process, or societal practice that constrains one from fully participating in society (Mullaly, 2007). Similarly, structural social work acknowledges the importance of social democracy and equity, and promotes social justice. Structural social work also recognizes the importance of history and acknowledges that "neither the life of an individual nor the history of a society can be understood without understanding both" (Mills 1959, cited in Mullaly, 2007, p. 295). Thus, structural social work goes hand in hand with Indigenous methodologies and approaches to practice, which helps to understand the nuanced maternal health in Ethiopia requiring a holistic social justice approach, in addition to medicalized health services.

Structural social work utilizes intrapsychic and interpersonal processes, in order to counteract the damaging effects of oppression, and build strength in the individual for developing community of solidarity (Mullaly, 2007). Structural social work also includes consciousness-raising and collectivization, which are critical elements in critical liberation. Individual work, group work, or community work could be used separately or in some combination to pursue these goals (Mullaly, 2007).

The study also reveals the importance of working with existing community based structures that already provide care and support for mothers, so as to make significant and

sustainable change in the arena of maternal health. The results also highly recommend the importance of culturally relevant programs and services in health facilities.

3. Implications for Social Work Education

A growing body of research indicates that social work education, with a focus on remedial and medical models, has failed to adequately address structural causes of social problems in African countries due to the wholesale adoption of Western Social Work curricula to the African context (Chogugudza, 2009; Burke & Ngonyani 2004; Rankopo & Osei-Hwedie, 2010; Adjei & Buor 2012; Sewpaul & Lombard, 2004). Therefore, this study uses and promotes Indigenous approaches and methodologies to better understand contextual factors which then lead to workable policies, programs and interventions that effectively address problems in a given community.

This study is also important to social work education in Ethiopia as it might shift the discourse on maternal health from a medical problem requiring medical approach, to a human rights and social justice issue that requires structural responses.

4. Future Direction

Tuhiwai argued that "research will benefit mankind conveys a strong sense of social responsibility" (p.112). feeling this sense of responsibility, my next step will be starting a community based action project to design culturally competent and quality maternal health program in North Wollo Zone, and document the process of service delivery. The findings of this research highlighted the importance of the processes in service delivery to enhance maternal health. Hence, in the coming project, I will assess how is the process different? What can we learn from it? Laying a strong foundation to project/program evaluation studies. I will continue to use Indigenous approaches and acknowledge the interdependency between women in the

community that is a profound based of their resilience and sustenance – the master's tools will never dismantle the master's house (Lorde, 1979)

Tuhiwai- Smith (2012) also reminds us that the research needs to be respectful, enabling, healing and educating. Through conducting community based participatory research I will create a respectful platform that provides research participants and community members a space to discuss and share their experiences – facilitating the education and healing, and enabling them to take part in their community development.

There is so much to do for any researchers who want to use indigenous approaches and build on this study. My kind reminder for those of you will be: get rid of your 'expert' mindset; and be willing to share your experience as a person. All the education – new 'findings' – emerge from genuine, respectful and reciprocal relationship. Moreover, a researcher need to go back to the roots of traditional wisdom and expertise, defy the myth that categorize indigenous wisdom as a 'thing of the past', and be open to learn and reflect. This way, there is so much to learn, discover and share. The whole process of Indigenous research, as Tuhiwai-Smith said, is a "humble and humbling activity" (p.5)!!!

APPENDICES

APPENDIX A: SEMISTRUCTURED INTERVIEW GUIDE

Leave box empty - For office use only

1. Basic demographic information
    - Address – district (*zone)*, county (*Woreda)* and neighborhood (*Kebele)* only
    - Age
    - Educational status
    - Marital status
    - Number of children
        - Age of children/ educational status of children/gender of children
2. How do you define/ regard motherhood?
    - Who are mothers?
    - How should mothers be treated? Why? Does that happen here?
3. What do mothers need to be healthy?
   Probes:
    - program based needs,
    - community resource needs,
    - spiritual needs, and
    - custom/ traditions based needs
4. Where do mothers get prenatal, natal and postnatal services in your community?
    - What kind of maternal health programs and services exist in your community?
    - Who provides those services?
        - Who should provide those services?
    - Are those services accessible? Why?
    - Are those services utilized? Why?
        - Who utilizes those services?
        - Have you ever used any maternal health services? Why? How do you rate the service?
5. Do mothers die while or shortly after giving birth in your community?
6. If so, what do you think is causing this death?
7. Can you tell me the contributions those services to enhance maternal health?

- formal institution based services rendered by government structures, private institutions, NGO based health services, and church based health services; and
- informal services rendered by community based associations, clan based association, neighborhood association, faith based fellowships

8. So far, to what extent have mothers' needs been met? By which sector – formal and informal sector?
    - program based needs,
    - community resource needs,
    - spiritual needs, and
    - custom/ traditions based needs
9. What do you think helped the most in addressing maternal health?
10. Are there any gaps between mothers' needs and available resources?
    - Formal/ institutionally available resources
    - Informal/ community and/or clan based resources
11. What do you think would improve maternal health in your community?

APPENDIX B. GUIDES FOR VISUAL INTERVIEWING

- Who is a mother? What is motherhood? Can you show me?
- What do you think of maternal mortality? How do you express it? Can you show me?
- How do you explain the gap between existing interventions/ programs and maternal health needs? How can we picture that gap?
- What should be done to reduce maternal mortality? Who should take part in enhancing maternal health? How would that look?

APPENDIX C: RESEARCH INFORMATION AND CONSENT FOR PARTICIPATION

Leave box empty - For office use only

University of Illinois at Chicago
Research Information and Consent for Participation in Social Behavioral Research
Towards Indigenous National Policies and Programs: Maternal Health in Ethiopia

You are being asked to participate in a research study. Researchers are required to provide a consent form such as this one to tell you about the research, to explain that taking part is voluntary, to describe the risks and benefits of participation, and to help you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Principal Investigator Name and Title: Aissetu Barry Ibrahima, Doctoral Candidate
Department and Institution: Jane Addams College of Social Work, University of Illinois at Chicago
Address and Contact Information: 1040 W Harrison, Chicago, IL 60607
Cell: 773-973-0947
Email: aibrah6@uic.edu
Contact information while in Ethiopia: P.O. Box-40388
Cell: 0911172545

Why am I being asked?

You are being asked to be a subject in a research study about maternal health in Ethiopia. I am exploring Indigenous ways that could enhance maternal health in Ethiopia learning from rural based mothers, who are targets of maternal health policies and programs.

You have been asked to participate in the research because you are a woman, who is older than 18 years old, and currently residing in North Wollo Zone of Ethiopia.
Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future dealings with the University of Illinois at Chicago or the agency you are currently seeking services from (if applicable). **If you decide to participate, you are free to withdraw at any time without affecting that relationship.**
Approximately 24- 30 subjects may be involved in this research at UIC.

What is the purpose of this research?

The purpose of this study is to understand why maternal morbidity and mortality continued to be one of the biggest challenges in Ethiopia, even after the country adopted international policies

and programs, which are under the umbrella of Millennium Development Goals (MDG). In this process the study will respond to the following research questions:

1. What supports does a mother need? In other words, how do the mothers who are intended to benefit from maternal health policies and programs, define their needs? [Program based needs, community resource needs, spiritual needs, and needs based on traditional practices]
2. To what extent have their needs been met? [By maternal health policies and programs, by community resources and traditional practices?]
3. What has helped the most?
4. What if any gaps remain? What do mothers think would improve their situation?

What procedures are involved?

If you agree to participate in the study, you will be asked to engage in the following study procedures:

1. One-time, in-depth, semi-structured interview. The purpose of this interview is to explore and understand maternal health needs and how these needs have been addressed within your community. During the interview, you will be asked to express your emotions and ideas through drawings, and/or sketches on paper or natural settings —on the ground. This interview is expected to last between one to two hours. All interviews will be conducted in person at a location and time of your choosing.

2. Member-check. The purpose of member-check is to review the study's preliminary findings and their congruence with participants' experiences and perspectives. In this process I will use Circles or "yarning circles" as Sheehan (2011) describes it, bringing 10-15 participants together, since circles will create a space where participants share their knowledge and experience without restraint.

The interview and/or member-check will be audio recorded and whether agreeing to this is mandatory for participation

What are the potential risks and discomforts?

This research involves minimal risk. To the best of my knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. However, if you experience emotional or psychological discomfort, we can take a break, skip the questions, or end the interview at any time. Moreover, I will not disclose to anyone that you are enrolled in the study. To adequately conceal your identity, all information will be de-identified immediately after transcription and pseudonyms will be assigned. You will decide the location and time of the interview. However, if you prefer to conduct the interview in a public place, it will be a risk to your privacy.

Moreover, there is the risk of a breach of privacy since others may find out that you are participating in this research, given the collectivist culture of the community. Moreover, their

could be a breach to confidentiality as others may find out identifiable information about the subject collected during the research, during members check.

Are there benefits to taking part in the research?

This research will not have direct benefit to you. However, it may have a societal benefit in shaping the knowledge/evidence base of maternal health policies and programs in Ethiopia.

What other options are there?

You have the option to not participate in this study.

What about privacy and confidentiality?

The people who will know that you are a research participant is the principal investigator. Moreover, other research participants participating in the member-check group will know that the subject is participating in the research. Otherwise information about you will only be disclosed to others with your written permission, or if necessary to protect your rights or welfare or if required by law.

Study information which identifies you and the consent form signed by you may be looked at and/or copied for checking up on the research by the UIC Office for the Protection of Research Subjects and State of Illinois auditors.

I would like to audio-record the interview so that I may keep accurate records of our conversation. In addition, I will take brief notes during the interview. After each interview, I will transcribe the interview. You will not be asked any identifying information during the interview and should any identifying information come up, it will be excluded or changed during the transcription process. Only the researcher will have access to the audio files. Interview transcripts will be deidentified and shared with research assistant/s that would help me in data analysis. All subject information forms and eligibility checklists will be stored in locked file cabinets separate from the study data. All electronic data files will be encrypted and stored on a password-protected computer that only the principal investigator has access to. In order to link your data over time, a list connecting your name, participant ID and pseudonym will be stored in a secure, locked file cabinet, separate from the study data. This list will be destroyed once data collection is completed. The audio file of your interview will be destroyed upon completion of the study. Only the principal investigator will have access to this audio file and the audio files will not be used for any other purpose besides this study.

Information you provide during the interview may be quoted directly in the findings of the study, however it will not be associated with any identifying information. You will be assigned a made-up name of your choosing during the interview that will identify your data. The researcher's dissertation committee, comprised of faculty supervising the study, will have access to the data only identified by made-up names.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

What are the costs for participating in this research?

There are no costs to you for participating in this research.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

You will receive $20 in cash for completed study visit, i.e., $8 (152birr) after completing the in-depth interview and $12 (228birr) after completing members check. It will be used to compensate and acknowledge your time.

Can I withdraw or be removed from the study?

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. You may also refuse to answer questions that you do not feel comfortable with or stop the interview at any time.

In the event you withdraw you will still be compensated as described above.

Who should I contact if I have questions?

Contact the researcher Aissetu Barry Ibrahima at (+1)7736730947 or 0911172545 or aibrah6@uic.edu, or her faculty sponsor, Mark Mattaini at (+1) 312 996-0040 or mattaini@ uic.edu, or UIC IRB at uicirb@uic.edu, or Abebe Abate, a faculty in Addis Ababa University School of Social Work, at 0911236153, or abihailu@gmail.com, if you have any questions about this study or your part in it, and/or if you have questions, concerns or complaints about the research.

Remember:

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

Signature of Research Participant

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I will be given a copy of this signed and dated form.

I give my permission to have the interviews audio-tape recorded ☐

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature of Person Obtaining Consent Date (must be same as subject's)

_____

Printed Name of Person Obtaining Consent

APPENDIX D: RESEARCH INFORMATION AND CONSENT FOR PARTICIPATION-AMHARIC VERSION

ዩኒቨርሲቲ ኦፍ ኤሊኖይ ቺካጎ

የጥናት መረጃና የተሳትፎ ማረጋገጫ

ጉዞ ወደ ሃገር በቀል ፖሊሲና ፕሮግራም፡ የእናቶች ጤና በኢትዮጵያ

ተመራማሪዎች ስለጥናተቸው የሚገልፅ በቂ መረጃ እንዲም የጥናት ተሳተፊዎች በፍቃደኝነት መሳተፋቸውን የሚገልፅ ማስረጃ እንዲያቀርቡ ህግ ያስገድዳቸዋል። ስለዚህ እርሶ በዚህ ጥናት ላይ በፍቃደኝነት እንዲሳተፉ ተመራማሪው ስለጥናቱ ጥቅም፤ እንዲሁም ጉዳት በግልፅ ሊነግርዎ ይገባል። በዚህ ወቅት የሚያነሱት ማንኛውም ጥያቄ ካለ ለተመራማሪው መጠየቅ ይችላሉ።

የተመራማሪ ሥም፡ አይሰቱ ባሪ ኢብራሂማ

የትምህርት ተቋሙ ሥም፡ ዩኒቨርሲቲ ኦፍ ኤሊኖይ ቺካጎ፤ ጀን አዳምስ ስኩል ኦፍ ሶሻል ወርክ

የትምህርት ተቋሙ አድራሻ፡ 1040 West Harrison St. M/C 309, Chicago, IL, 60607

በዚህ ምርምር ውስጥ ለምን እሳተፋልሁ?

ተመራማሪዋ በኢትዮጵያ ውስጥ የእናቶች ጤና እንዴት እንደሚጠበቅ በተለይም በገጠሪቷ ኢትዮጵያ እናቶች/ ሴቶች ጤናቸውን ለመጠበቅ የሚያደርጉትን ጥረት፤ ወጋቸውን፤ልምዳቸውን እንዲሁም ባህላቸው በጤናቸው ዙሪያ ያለውን አስተዋፅዖ እንዲሁም ተፅዕኖ ለማወቅ ምርምር ያደርጋሉ። እርሶም ሴት በመሆኖ፤ እድሜዎም ከ18ዓመት በላይ በመሆኑ፤ ማገናዘብ በመቻልዎና የሰሜን ወሎ ዞን ነዋሪ በመሆኖ በዚህ ምርምር ውስጥ እንዲሳተፉ በክብር ተጠይቀዋል።

የርስዎ ተሳትፎ ሙሉ በሙሉ በፍቃደኝነትዎ ላይ የተመሰረተ በመሆኑ ወደፊት ውሳኔዎ ወደፊት ከትምህርት ቤቱ ጋር የሚኖርዎትን ግንኙነት አያደናቅፍም። ለመሳተፍ ከወሰኑም በኋላ በማንኛውም ጊዜ ተሳትፎዎን ማቋረጥ ይችላሉ።

የጥናቱ አላማ

ሃገራችን ኢትዮጵያ አለማቀፋዊውን የሚሊኒየም ዕድገት ግብ ተቀብላ የጤና ፖሊሲዎችዋ አካል አድርጋ መቀበልዋ ይታወቃል። ነገርግን ከወሊድ ጋር በተያያዘ በእናቶች ላይ የሚከሰተውን አካል ጉዳተኝነትን እንዲሁም ሞት በሃገራችን አስጊ ደረጃ ላይ ይገኛል።

ስለዚህ ይሄ ጥናት የሚከተሉትን ጥያቄዎች ከነባራዊ ሁኔታዎች ጋር በማተያየት ለመመለስ ይሞክራል።

1. እናቶች ምን አይነት እርዳታ ያስገልጋቸዋል? ይህንን ፍላጎታቸውን እንዴት ይገልጹታል?
2. ይሄ ፍልጎታቸው ምን ያህል ተማልተዋል?
3. የእናቶችን ጤና ፍላጎት ለሟሟላት የትኛው ተቋም ከፍተኛ ሚና ተጫውቷል?
4. ያልተሟሉ ፍላጎት ካለ ምድነው? እንዴትስ ይሟላል ብለው ያስባሉ?

የጥናቱ ሂደት

ይህ ጥናት የሚከተሉትን ክንውኖች ያጠቃልላል፦

1. **መጠይቅ**፡ ይህ መጠይቅ የእናቶችን ጤና አጠባበቅ ሁኔታን ለመረዳት የሚከናወን ሲሆን ከ1-2 ሰዓት ሊፈጅ ይችላል። በዚህ ወቅት ስሜቶን በስዕል ወይም በቅርፃ ቅርፅ እንዲገልፀ ይጠየቃሉ።
2. **ግብረ-መልስ**፡ መጠይቁ ተጠናቆ ተመራማሪዋ የመጀመሪያውን ጥናታዊ ጽሁፉን ከጨረሱ በኋላ የተሳታፊዎቹን ሃሳብ በአጠቃላይ መልኩ በጥናታቸው ውስጥ

ማካተታቸውን ለማወቅ የሚካሄድ ይሆናል። በዚህ ሂደት ውስጥ ተሳታፊዎች ክብ ሰርተው በመቀመጥ ተራ በተራ ሀሳባቸውን እንዲገልጹ ይጠየቃሉ።

በጥናቱ ውስጥ በመሳተፍ ሊለከሰት የሚችል ችግር

በዚህ ጥናት ውስጥ በመሳተፎት በርስዎም ሆነ በቤተሰብዎ ላይ የሚደርስ አንዳች ችግር አይኖርም። ነገር ግን በመጠይቁ ወቅት የሚነሱ ጥያቄዎቹን ለመመለስ የሚከብድዎት ከሆነ ጥያቄውን ያለመመለስ ወይም መጠይቁን የመተው መብት አሎት። ይህን በማድረጎም የሚደርስ ምንም ተጽዕኖ አይኖርም።

በመጠይቁ ወቅት የሚሰጡት መረጃ ከተመራማሪው በስተቀር ለማንም አይነገርም። በሚጻፍበት ወቅትም የርስዎ ስምም ሆነ አድራሻ በፍጹም አይገለጽም። በስምዎ ፋንታ እርሶ የመረጡት ሌላ ስም ይተካል።

መጠይቁን ሰው በበዛበት ቦታ ላይ ለማካሄድ ከመረጡ በአካባቢው ያለው ሰው የጥናት ተሳታፊ መሆኖን ሊጠረጥር ይችላል። ስለዚህ በዚህ ጥናት መሳተፍዎቱን ማንም እንዲያውቅ ካልፈለጉ መጠይቁን በተከለለ ቦታ ላይ ማድረግ ይቻላል።

በጥናቱ ወቅት በሚሳተፉበት ግዜ የመሳተፍ ውሳኔዎን የሚነካ አዲስ መረጃ ካለ ይነገሮል።

በዚህ ጥናት ውስጥ መሳተፍ የሚያስገኘው ጥቅም

በዚህ ጥናት ውስጥ መሳተፍ ለእርሶን በቀጥተ የሚያስገኘው ጥቅም አይኖርም። ነገርግን የሃገሪቷን የእናቶች ጤና ፖሊሲ ሊያሻሽል ይችላል።

ሌላ ምን አማራጭ አለኝ?

በዚህ ጥናት ውስጥ አለመሳተፍ ይችላሉ።

ግለሰባዊ ማንነትና ሚስጢር መጠበቅ

በዚህ ጥናት ውስጥ ተሳተፊ መሆኖትን የሚያውቅ ተመራማሪው ብቻ ሲሆን የአርሶን መረጃ የያዘው የተሳትፎ ማረጋገጫ ከተመራማሪዋ ሌላ የሚተየው በአሜሪካ በሚገኙ በአዲተሮች ብቻ ይሆናል።

በመጠይቁ ወቅት መልሶን በትክክል ለመያዝ ቃለ ምልልሱን በመቅፀ-ድምፅ ይቀዳል። በተጨማሪም አጫጭር ማስተወሻዎችን አወስዳለሁ። የተቀረጸውንም መረጃ ከተመራማሪዋ በስተቀር ማንም አያዳምጠውም። ተጨማሪ ቅጾችና ፋይሎች በሳጥን ውስጥ ተቆልፈው ይቀመጣሉ። ጥናቱ በሚያልቅበት ወቅት መቅረፀ ድምፁ ላይ ያለው መረጃ ይደመሰሳል።

ጥናቱ ውስጥ መሳተፍ ያለው ወጪ

አዚህ ጥናት ውስጥ ለመሳተፍ የሚያወጡት ወጪ ምንም አይኖርም።

በዚህ ጥናት ላይ ለመሳተፍ የሚከፈለኝ ገንዘብ አለ?

በዚህ ጥናት ውስጥ ለመሳተፍ ከወሰኑ መጠይቁን አንደጨረሱ 20 ዶላር ምንዛሪ ይከፈሎተል።

ተሳትፎዬን ማቋረጥ አችላለሁ?

በማንኛውም ሰዓት ይህንን ጥናት ማቋረጥ ይችላሉ።

ጥያቄዎች ካሉኝ ማንን ላነጋግር?

ማንኛውንም ከጥናቱ ጋር የተያያዘ ያሎትን ጥያቄ/ዎች ተመራማሪዋን- አይስቱ ባሪ ኢብራሂማን በስልኳ *0911172545* ወይም በኢሜል- aibrah6@uic.edu ማነጋገር ይችላሉ። በተጨማሪም አዲስ አበባ ዩኒቨርሲቲ የሚገኘውን ዶር. አበበ አባተን በ*0911236153* ማነጋገር ይችላሉ።

ማስተወሻ

የርስዎ ተሳትፎ ሙሉ በሙሉ በፍቃደኝነትዎ ላይ የተመሰረተ በመሆኑ ወደፊት ውሳኔዎ ወደፊት ከትምህርት ቤቱ ጋር የሚኖርዎትን ግንኙነት አያደናቅፍም። ለመሳተፍ ከወሰኑም በኋላ በማንኛውም ጊዜ ተሳትፎዎን ማቋረጥ ይችላሉ።

የተሳተፊዎች ፊርማ

ከላይ የተጻፈውን መረጃ አንብቤ/ ተነቦልኝ ተረድቻለሁ። ያሉኝንም ጥያቄዎች አንስቼ አጥጋቢ መልስ አግኝቻለሁ። በዚህ ጥናት ውስጥ ለመሳተፍም ተስማምቻለሁ። ፊርማዬ የሰፈረበት የዚህ ቅፅ ግልባጭ ይሰጠኛል።

መጠይቁ በመቅረፀ ድምፅ እንዲቀዳ ተስማምቻለሁ። ☐

ፊርማ: _____ **ቀን**: _____

ስም: _____

የተመራማሪው ፊርማ: _____ **ቀን**: _____

ስም: _____

APPENDIX E: RESEARCH ASSISTANTS TRAINING PROTOCOL

Training outline

- General overview of the study
- Applying CITI Training to the study
- Indigenous Approaches and Qualitative Research

Copy of Research Assistant Training: Powerpoint slides

Research Assistants Training Protocol

Aissetu Barry Ibrahima

University of Illinois at Chicago
Jane Addams School of Social Work

Presentation Contents

- General overview of the study
- Applying CITI Training to the study
- Indigenization: Definition & concepts
- Introduction
- Using Indigenous Approaches in Qualitative Research
- Why Indigenous Approaches?
- Important considerations in indigenous Approaches
- Concluding remarks

General overview of the study

- Rationale and significance of the study
  - Chapter 1-p.12-16 of the study protocol
- Conceptual framework of the study
  - Structural social work; Indigenous Approaches (p-18-20; p-69-81 of the study protocol)
- Study methodology 0
  - Indigenous Methodology
  - Qualitative study (p- 85-96 of the study protocol)

Applying CITI training to the study

- What is human subject training?
- What is informed consent?
- What do we mean by privacy?
  - What is breach to privacy?
- What do we mean by confidentiality?
  - What is breach to confidentiality?
- Why is privacy and confidentiality important?
- What is coercion? How do we prevent it?

Introduction

- Indigenous knowledge and research methodologies have always been with us and Indigenous cultures are rich with ways of gathering, discovering, and uncovering knowledge (Tuhiwai-Smith, 2012; Sheehan, 2011)
- Indigenous knowledge addresses issues of location, politics, identity, culture, and the history of people in relation to the lands they inhabit
- Indigenous methodologies can be situated within the qualitative landscape, because they value both process and content (Kovach, 2010)

Introduction… contd

- Qualitative methodologies allow substantial flexibility to research design and data analysis, thus nurturing reciprocal relationships with participants.
- Qualitative methodologies allow collaboration and participation in local development and action, which can emancipate social change, thereby serving the needs of Indigenous communities in their struggle for self-determination (Kovach, 2010)
- In this research Indigenous values are incorporated throughout the research process, and local norms and traditions are respected as research opens up to a broader range of perspectives.

Indigenization: Definitions and Concepts

- Indigenization is the development of culture specific knowledge and practice (Gray & Coats, 2010).
- It is about developing local, empirically based knowledge about culturally appropriate solutions to particular contexts (Gray & Coats, 2010; Rankopo & Osei- Hwedie, 2011).
- Indigenization recognizes the presence of cultural diversity, and the importance of developing culturally relevant practice approaches.

Indigenization… cont

- 'Indigenization' is against the attempt of 'internationalization' and 'standardization' (Gray & Coats, 2010; Rankopo & Osei- Hwedie, 2011).
- it can also be understood as a process of decentering colonial discourse and power structures through tactics that can be resistant or more confrontational (Gray & Coats, 2010, p. 623).
- it can also be understood as a process of decentering colonial discourse and power structures through tactics that can be resistant or more confrontational (Gray & Coats, 2010, p. 623).

Indigenization….cont

- In progressing towards Indigenous approaches, it is important to move to authentization, which is a culturally appropriate approach that requires becoming genuine, or going back to one's root to seek direction, moving away from adopting and modifying Western social work theory and practice (Gray & Coates 2010, p.5).

Why Indigenous Approaches?

- Methodology is important because
  - it frames the question being asked,
  - determines the set of instruments and methods to be employed, and shapes the analysis (Denzin & Lincoln, 2008; Matsinhe, 2007; Nicholls, 2009; Tuhiwai-Smith, 2012).
  - "methodology legitimates and delegitimates, validates and invalidates, approves and disapproves, passes and fails, claims to knowledge and knowledge production" (Matsinhe, 2007) .

Why Indigenous Approaches…contd

- Indigenous approaches are appropriate to the needs of Indigenous communities as it can emancipate social change (Kovach, 2010)
- Indigenous inquiry is always grounded in principles centered on autonomy, home, family and kinship as it presupposes a shared collective community vision (Denzin & Lincoln, 2008).

Why Indigenous… contd

- Indigenous methodology is also a tool for social activism and theory, which can be mobilized as resistance and transformation (Davis, Williams & Akinyela, 2010; Morgensen, 2012, Semali & Kincheloe, 1999).
- Indigenous research challenges objective, value-free, and scientific process for observing and analyzing human reality, due to the emphasis placed on deterministic models of analysis and its denial of culture as a mediating force (Davis, Williams & Akinyela, 2010; McCleland, 2011; Tuhiwai-Smith, 2012).

Important considerations in indigenous social work

- diversity,
- history,
- Culture, and
- Contemporary realities (Weaver, 1999)

Diversity

- working with indigenous communities, we need to pay attention to differences in language and communication patterns, traditions, and norms.

History

- Indigenous research challenges the so called objective, value-free, and scientific process for observing and analyzing human reality, due to the emphasis placed on deterministic models of analysis and its denial of culture as a mediating force (Davis, Williams & Akinyela, 2010; McCleland, 2011), Tuhiwai-Smith, 2012).

Culture

- culture defines people's daily life and patterns of interaction
- Culture: is an identity. It is important to pay attention to social structures and patterns of communication
  - Examples: women interact differently in presence of men, especially, religious leaders, elders
  - Religion and spirituality play significant roles in individuals as well as communal life in Africa.

Culture…. contd

- Valuing extended family system and respect for elders: households are never perceived crowded in many African cultures
- Using traditional leaders and elders as community mediators, and gatekeepers is very important. community take the major role.
- Understanding the livelihood is also important

Concluding remarks

- Developing indigenous approaches requires a balance, challenging dominant models of social work practice and research, while integrating traditional values and practices that have withstood centuries of oppression into culturally consonant forms of service and inquiry.
- Indigenous approaches can serve as an intersection bringing policies, interventions and the grassroots together.

APPENDIX F: GATEKEEPERS RECRUITMENT SCRIPT

Leave box empty - For office use only

Greetings of Peace!

I am contacting you since you are very influential member of your community as (*the profession/title/background of the person)*. You also know the dwellers of your community very well.

[As you may know] My name is Aissetu Barry Ibrahima. I am a doctoral student at Jane Addams College of Social Work at University of Illinois at Chicago and conducting my dissertation research project on maternal health situations in Ethiopia. I am exploring Indigenous ways that could enhance maternal health in Ethiopia learning from rural based mothers, who are targets of maternal health policies and programs.

The purpose of this study is to understand why maternal morbidity and mortality continued to be one of the biggest challenges in Ethiopia, even after the country adopted international policies and programs, which are under the umbrella of Millennium Development Goals (MDG). In this process the study will respond to the following research questions:

1. What supports does a mother need? In other words, how do the mothers who are intended to benefit from maternal health policies and programs, define their needs? [Program based needs, community resource needs, spiritual needs, and needs based on traditional practices]
2. To what extent have their needs been met? [By maternal health policies and programs, by community resources and traditional practices?]
3. What has helped the most?
4. What if any gaps remain? What do mothers think would improve their situation?

Currently, I need research participants who would take part in this study. Potential research participants of this research would be:

- Woman,
- More than 18, and
- Currently residing in North Wollo Zone

Please keep in mind that your help in facilitating this research process is completely voluntary. You may accept or reject this offer. Moreover, potential participants also take part in this research voluntarily. They should not feel obliged to participate in this research.

I am very confident that you would be able to help me identify potential research participants who are part of your circle of influence. Ones you identified them, we will both contact them for the first time. Your presence in the first contact will facilitate our communication as you have personal relationship with potential research participants.

Thank you so much for your time and hospitality!

APPENDIX G: RECRUITMENT SCRIPTS TO BE USED DURING THE INFORMATIONAL SESSION

Leave box empty - For office use only

Greetings of Peace!

I hope you would remember me as we meet last time with *insert the name of the gatekeeper*. As you may remember, my name is Aissetu Barry Ibrahima. I am a doctoral student at Jane Addams College of Social Work at University of Illinois at Chicago and conducting my dissertation research project on maternal health situations in Ethiopia. I am exploring Indigenous ways that could enhance maternal health in Ethiopia learning from rural based mothers, who are targets of maternal health policies and programs.

Thank you so much for showing your interest in this research and for scheduling this informal session. In this session I want to tell you a little more about my dissertation research and the consent process. Your participation is absolutely voluntary. Even if you know and respect *name if the gatekeeper* you will not be obliged to participate in this study. He/she [*the gatekeeper]* will not be informed about your decision to participate in this research or not, thus you can decide freely.

The purpose of this study is to understand why maternal morbidity and mortality continued to be one of the biggest challenges in Ethiopia, even after the country adopted international policies and programs, which are under the umbrella of Millennium Development Goals (MDG). In this process the study will respond to the following research questions:

1. What supports does a mother need? In other words, how do the mothers who are intended to benefit from maternal health policies and programs, define their needs? [Program based needs, community resource needs, spiritual needs, and needs based on traditional practices]
2. To what extent have their needs been met? [By maternal health policies and programs, by community resources and traditional practices?]
3. What has helped the most?
4. What if any gaps remain? What do mothers think would improve their situation?

If you consented to participate in this research you would be asked to participate in a onetime in-depth interview which explore about maternal health needs and how these needs have

been addressed within your community. During the interview, you will be asked to express your emotions and ideas through drawings, and/or sketches on paper or natural settings —on the ground. This interview is expected to last between one to two hours. All interviews will be conducted in person at a location and time of your choosing. Moreover, you will be invited to participate in member-check. The purpose of member-check is to review the study's preliminary findings and their congruence with participants' experiences and perspectives. In this process I will use Circles or "yarning circles" as Sheehan (2011) describes it, bringing 10-15 participants together, since circles will create a space where participants share their knowledge and experience without restraint. The interview as well as the member-check session will be audio recorded and agreeing to this is mandatory for participation.

The audio-record will help me keep accurate records of our conversation. In addition, I will take brief notes during the interview. After each interview, I will transcribe the interview. You will not be asked any identifying information during the interview and should any identifying information come up, it will be excluded or changed during the transcription process. Only the researcher will have access to the audio files. Interview transcripts will be deidentified and shared with research assistant/s that would help me in data analysis. All subject information forms and eligibility checklists will be stored in locked file cabinets separate from the study data. All electronic data files will be encrypted and stored on a password-protected computer that only the principal investigator has access to. In order to link your data over time, a list connecting your name, participant ID and pseudonym will be stored in a secure, locked file cabinet, separate from the study data. This list will be destroyed once data collection is completed. The audio file of your interview will be destroyed upon completion of the study. Only the principal investigator will have access to this audio file and the audio files will not be used for any other purpose besides this study.

This research involves minimal risk. To the best of my knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. However, if you experience emotional or psychological discomfort, we can take a break, skip the questions, or end the interview at any time. Moreover, I will not disclose to anyone that you are enrolled in the study. To adequately conceal your identity, all information will be de-identified immediately after transcription and pseudonyms will be assigned. You will decide the location and time of the interview. However, if you prefer to conduct the interview in a public place, it will be a risk to your privacy.

Moreover, there is the risk of a breach of privacy since others may find out that you are participating in this research, given the collectivist culture of the community. Moreover, there could be a breach to confidentiality as others may find out identifiable information about the subject collected during the research, during members check.

This research will not have direct benefit to you. However, it may have a societal benefit in shaping the knowledge/evidence base of maternal health policies and programs in Ethiopia.

Information you provide during the interview may be quoted directly in the findings of the study, however it will not be associated with any identifying information. You will be assigned a made-up name of your choosing during the interview that will identify your data. The researcher's dissertation committee, comprised of faculty supervising the study, will have access to the data only identified by made-up names.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

You will receive $20 in cash for completed study visit, i.e., $8 (152birr) after completing the in-depth interview and $12 (228birr) after completing members check. It will be used to compensate and acknowledge your time.

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. You may also refuse to answer questions that you do not feel comfortable with or stop the interview at any time.

In the event you withdraw you will still be compensated as described above.

If you have any questions, comments, concerns or complaints about the research, you may contact:

- the researcher Aissetu Barry Ibrahima at (+1)7736730947 or 0911172545 or aibrah6@uic.edu,
- her faculty sponsor, Mark Mattaini at (+1) 312 996-0040 or mattaini@ uic.edu,
- UIC IRB at uicirb@uic.edu,
- Abebe Abate, a faculty in Addis Ababa University School of Social Work, at 0911236153, or abihailu@gmail.com, have questions,

Remember:

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

Thank you so much for your time and hospitality!

APPENDIX H: OBSERVATION LOG

Leave box empty - For office use only

I will carry out my observation in a selected **places of worship, a market place, and a hospital**, to see how women are interacting and carry out their routines. This would help me understand the role and position of women [as girls, mothers, and elders] in their community in order to develop relevant and accessible maternal health programs and strategies. No personal information will be recorded in my observation notes.

I will also observe how their geographical location impact women's access and use of maternal health services. Thus, I will observe the presence and/or absence of

1. transportation,
    - Availability of public and private means of transportation (cars- what kind? animals – what kind?)
    - how accessible are roads
2. energy at household level and in public facilities
    - electricity,
    - gas,
    - solar,
    - biogas
3. communication
    - Internet,
    - telephone,
    - mobile phone,
    - fax
4. public and private facilities,
    - schools,
    - hospitals,
    - market places,
    - grocery stores,
    - Places of worship and rituals.

-

APPENDIX I: LETTER OF SUPPORT FROM ADDIS ABABA UNIVERSITY

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ADDIS ABABA UNIVERSITY

የሶሻል ወርክ ትምህርት ቤት SCHOOL OF SOCIALWORK

Date: July 20, 2014
Ref: SSW/210/07/14

To: Aissetu Barry Ibrahima
Jane Addams College of Social Work
University of Illinois at Chicago

Subject: Letter of Support

The purpose of this letter is to confirm that your PhD thesis proposal titled "Towards Ingenious national polices and programs, maternal health in Ethiopia" is guided by the general principle of the School of Social Work at Addis Ababa University. The school believes that your dissertation topic has multidimensional relevance including social work research, social welfare policy, social work education and practice in Ethiopia.

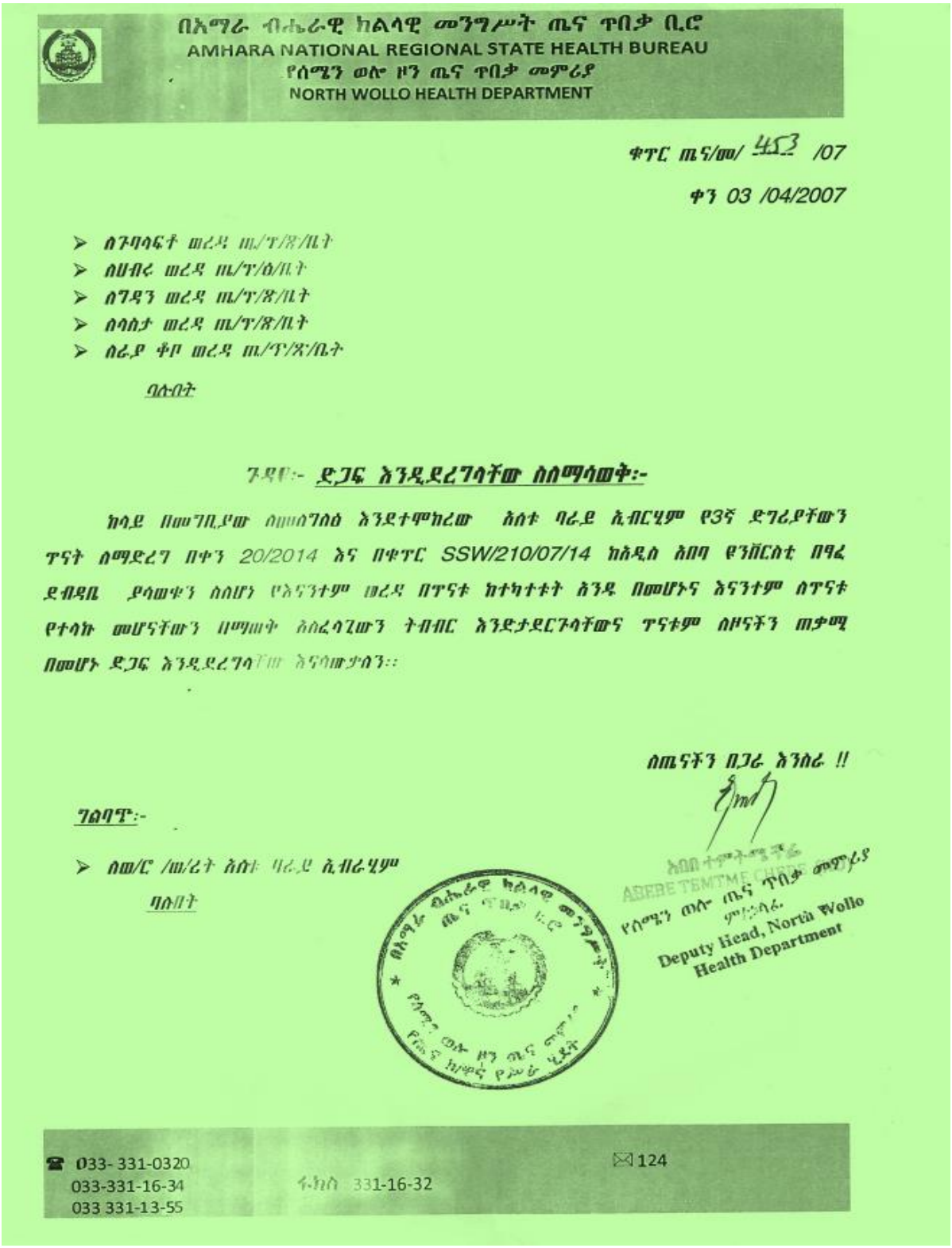
Considering the relevance of your research, the School of Social Work is pleased to assist you in the following areas:

- Validating the data collection instruments,
- Facilitating expert review meeting on both data collection process and draft report,
- Linking the researcher with the informants through writing a support letter to the concerned organizations,
- Facilitating the local proposal review through the local Institutional Review Board.

Best Wishes,

Mengestu Legesse (PhD)
Head, School of Social Work,
Addis Ababa University

APPENDIX J: LETTER OF RESEARCH APPROVAL FROM FROM NORTH WOLLO ZONE HEALTH BUREAU



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AMHARA NATIONAL REGIONAL STATE HEALTH BUREAU
የሰሜን ወሎ ዞን ጤና ጥበቃ መምሪያ
NORTH WOLLO HEALTH DEPARTMENT

ቁጥር ጤና/መ/ 453 /07

ቀን 03 /04/2007

- ለጉባላፍቶ ወረዳ ጠ/ጥ/ጽ/ቤት
- ለሀብሩ ወረዳ ጠ/ጥ/ፅ/ቤት
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- ለሳሰታ ወረዳ ጠ/ጥ/ጽ/ቤት
- ለራያ ቆቦ ወረዳ ጠ/ጥ/ጽ/ቤት

ባሉበት

ጉዳዩ:- **ድጋፍ እንዲደረግላቸው ስለማሳወቅ:-**

ከላይ በመግቢያው ለዘረዘርነው እንደተመከረው አሰቱ ባራይ ኢብርሂም የ3ኛ ድግሪያቸውን ጥናት ለማድረግ በቀን 20/2014 እና በቁጥር SSW/210/07/14 ከአዲስ አበባ ዩንቨርስቲ በላፈ ደብዳቤ ያሳወቁን ስለሆነ ሆስፒታሉም ወረዳ በጥናቱ ከተካተቱት አንዱ በመሆኑና እናንተም ለጥናቱ የተሳኩ መሆናቸውን ለማጠቅ ስለፈላጊውን ትብብር እንድታደርጉላቸውና ጥናቱም ለዞናችን ጠቃሚ በመሆኑ ድጋፍ እንዲደረግላቸው እናሳውቃለን::

ለጤናችን በጋራ እንስራ !!

ግልባጭ:-

- ለወ/ሮ /ሠ/ሪት አሰቱ ባራይ ኢብራሂም

ባሉበት

አበበ ተምትሜ ጌራ
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ምክትል ሃ.
Deputy Head, North Wollo Health Department

☎ 033- 331-0320
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APPENDIX K: IRB APPROVAL LETTER

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Approval Notice

Continuing Review

September 22, 2015

Aissetu Ibrahima
Jane Addams School of Social Work
1040 W Harrison
M/C 309
Chicago, IL 60612
Phone: (773) 673-0947 / Fax: (312) 996-2770

RE: **Protocol # 2014-0737**

"Towards Indigenous National Policies and Programs: Maternal Health in Ethiopia"

Dear Ms. Ibrahima:

Your Continuing Review application was reviewed and approved by the Expedited review process on September 17, 2015. You may now continue your research.

Please note the following information about your approved research protocol:

Please remember to submit an amendment for the post-analysis group member checks before implementing that phase of the research.

Protocol Approval Period:	September 17, 2015 - September 16, 2016
Approved Subject Enrollment #:	30 (limited to member checks with 30 enrolled subjects)

Additional Determinations for Research Involving Minors: These determinations have not been made for this study since it has not been approved for enrollment of minors.

Performance Sites: UIC, Addis Ababa University

Sponsor: None

Research Protocol:

a) Towards Indigenous National Policies and Programs: Maternal Health in Ethiopia; Version 2; 08/29/2014

Recruitment Material:

a) N/A – limited to member checks and data analysis only

Informed Consent:

a) N/A – limited to member checks and data analysis only

Your research continues to meet the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes., (7) Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note the Review History of this submission:

Receipt Date	Submission Type	Review Process	Review Date	Review Action
09/11/2015	Continuing Review	Expedited	09/17/2015	Approved

Please remember to:

→ Use your **research protocol number** (2014-0737) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements on the OPRS website under:

"UIC Investigator Responsibilities, Protection of Human Research Subjects"
(http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)

Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 996-2014. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,

Sandra Costello

Assistant Director, IRB # 2

Office for the Protection of Research Subjects

cc: Creasie Hairston, Jane Addams School of Social Work, M/C 309
Mark A. Mattaini (faculty advisor), Jane Addams School of Social Work, M/C 309

APPENDIX L: PICTORIAL REPRESENTATION OF MOTHERHOOD – FROM ALEM'S (RESEARCH PARTICIPANT) PICTURE GALLERY

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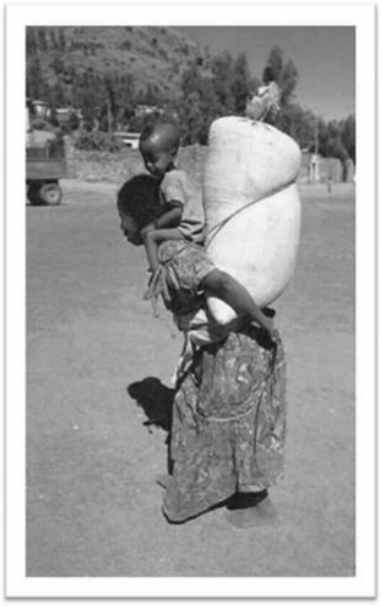
በሌላው ቀለብሽ . . .
ኧረ ይደጉልሽ ሁለቱም ይክበዱ
አንቺን ያበርታልን ይመችሽ መንገዱ
አጋዥ ይዘዝልሽ የበረታ ክንዱ
ውለታሽን ይወቅ ያመስግን ትውልዱ።
«አይዞሽ!» የሚልሽ ይብዛልሽ ዱግ ሰው
ድካምሽን ልፋትሽን አምላክ ይመልከተው።

ቴምድሮስ አበበ
ሚያዝያ ፩ ቀን ፳፻፮ ዓ.ም



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VITA

AISSETU BARRY IBRAHIMA, MSW, PHD

3250 WHITFIELD AVE, CINCINNATI, OH, 45220 Ibrahia@miamioh.edu (773) 956-2272

EDUCATION

Ph.D., Social Work, (passed dissertation defense on September 9, 2016)
University of Illinois at Chicago
Dissertation: *Towards Indigenous Policies and Programs: Maternal Health in Ethiopia*

M.S., Social Work, 2006
Addis Ababa University, Ethiopia
Thesis: *Parents and Children in 'Empty Shell' Families: A Case Study on Selected Families Residing in Addis Ababa*.

B.A., Sociology and Social Administration, 2004
Addis Ababa University, Ethiopia
Thesis: *Divorce and Its Psychosocial and Economic Impacts On Mothers and Their Children*

TEACHING EXPERIENCE

Miami University – Hamilton, OH
Clinical Faculty, Family Studies and Social Work, 2016 – present
- FSW 201 – Introduction to Social Work
- FSW206 – Social Welfare Impact on Diverse Groups

University of Illinois at Chicago
Instructor, Jane Addams College of Social Work, 2015 –2016
- SocW 411 – Critical Social Work in a Multicultural Society
- SocW 460 – Social Work Research Foundations

Trinity College, Ethiopia
Instructor

RESEARCH EXPERIENCE

Conference Presentation

Ibrahima. A. B. *Towards Indigenous National Policies and Programs: Maternal Health in Ethiopia*. The 21st Annual Conference of the Society for Social Work and Research (SSWR) New Orleans, LA, January 2017.[9]

Ibrahima. A. B. *Asset Based Community Development (ABCD): An Alternative Path for Community Development*. The 19th International Symposium of the International Consortium for Social Development (ICSD), SIM University, Singapore, 7 – 10th July 2015.

Ibrahima. A. B. *Decolonizing Methodologies in the Helping Profession: Social Work in Africa.* Southwest/ Texas Popular Culture and American Culture Associations 34th Annual Conference, Albuquerque, New Mexico, 2013

Ibrahima. A. B. *MDGs, Educational Policies and Girls' education in Ethiopia: Current Trends and Prospects Beyond 2015,* 18th Biennial International consortium for Social development (ICSD), Kampala, Uganda, 2013

Ibrahima. A. B. *Practical Role of Religion in Shaping Gender Relations: The Case of the Ethiopian Orthodox Tewahido Church*, Gender Forum, Heinrich Boll Foundation, Addis Ababa, Ethiopia, 2009

Ibrahima. A. B. *Women in Peacebuilding, National Conference On Peacebuilding and Conflict Resolution*, Woliso, Ethiopia, 2008

Ibrahima. A. B. *The Role of the Youth in Peace Building and Conflict Resolution*, Grantees Meeting, Trust Africa, Nairobi, Kenya, 2007

PRACTICE EXPERIENCE

I have more than 6 years of field experience working with several Non-Governmental Organizations at various capacities – conducting need assessment, project and program design, budgeting and grant management, community mobilization, fundraising, monitoring and evaluation. Moreover, I have experience in organizing events and trainings, team building, and counseling.

PROFESSIONAL EXPERIENCE

University of Illinois at Chicago
Research Assistant, 2011 – 2015

- Find relevant articles for the project, write literature review, conduct electronic data entry (SPSS and STATA),
- Analyze quantitative as well as qualitative data
- Revise training manuals for practitioners working in substance abuse

Professional Alliance for Development (PADet), Ethiopia

Research and Training Advisor, 2010 – 2011

- Carried out baseline assessments and monitoring and evaluation researches

[9] Scheduled for presentation

- Coordinated the training and research activities of the agency
- Prepared monthly and annual reports documenting program activities
- Conducted staff performance evaluations
- Assisted the program manager in formulating projects and monitoring program implementation
- Served as member of the Program management team within PADet

Professional Alliance for Development (PADet), Ethiopia

Program Advisor [RH/HIV/AIDS], 2009 – 2010
- Reviewed and developed polices that guide the planning and implementation of reproductive health and HIV/AIDS programs
- Lead the program design and appraisal process for RH/HIV/AIDS related programs
- Lead and/or coordinate the tasks of Reproductive health team and provided technical assistance in areas of policy and program development, monitoring and evaluation
- Lead and facilitate research based advocacy initiatives
- Served as focal person for RH/ HIV/AID programs ensuring the implementation of projects/programs according to signed agreements with donor and government signatories, timely submission of reports to donors and other signatory bodies
- Supervised proper execution of assignments by zonal and/or area program officers and evaluated their performance
- Served as member of the Program management team within PADet

Interfaith Peace Building Initiative, Ethiopia

Executive Director, 2006 – 2008
- Promoted the vision, mission, and core values of the association
- Created and implemented new policies and guidelines upon the Board's approval
- Responded to the official correspondence of the organization
- Supervised the proper discharge of responsibilities of 10 staff members and 12 volunteers
- Managed the organizational budget
- Prepared progress and financial reports for concerned stakeholders
- Developed and maintained positive internal and external relations of the organization

REFERENCES

Mark Mattaini, DSW
Associate Professor (retired)
University of Illinois at Chicago
mamattaini@gmail.com

James Gleeson, PhD
Associate Professor
University of Illinois at Chicago
jimglee@uic.edu; (312) 996-0042

Brian L. Kelly, PhD
Assistant Professor
Loyola University – Chicago
Bkelly6@luc.edu; (312) 915-7479